Montgomery County Department of Health and Human Services

Measuring Progress

Report 1998

Contact: Arleen Rogan
401 Hungerford Drive, 7th Floor
Rockville, Maryland 20850
email: rogana@co.mo.md.us

Montgomery County
Department of Health and Human Services
Charles L. Short, *Director*

Department of Health and Human Services
Outcomes Management Team

Daryl Plevy
Arleen Rogan
Patricia Vorus
Accountability and Customer Service

DHHS Program Measure Work Group

Arleen Rogan, *Accountability and Customer Service*, Co-Chair
John Park, Ph.D, *Public Health Services,* Co-Chair
Fran Schorr, Ph.D., *Metis Associates,* Technical Consultant

Peter Luongo, Ph.D.
Mace Summers, Ph.D.
Adult Mental Health and Substance Abuse Services

Judy Covich
Ann Burton
Carol Clurman
Terry Farrell
Children, Youth and Family Services

Zaida Arguedas
Ken Steger
Daryl Plevy
Accountability and Customer Service

Odile Saddi
June Galloway
Linda Anderson
Aging and Disability Services

Carol Jordon
Richard Helfrich
Public Health Services

Carol Pearson
Cythia Anderson
Dudley Warner
Crisis, Victim and Income Services

Sherwin Collette
Management Services

Technical Support

Marya Booker
Michael Brown
Peggy Bur
Joanna Clarke
Mary Kay D'Addario
Jane Fidler
Carol G. Garvey, MD, MPH
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Suzy Houston
Lois Kietur
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Jane Larsen
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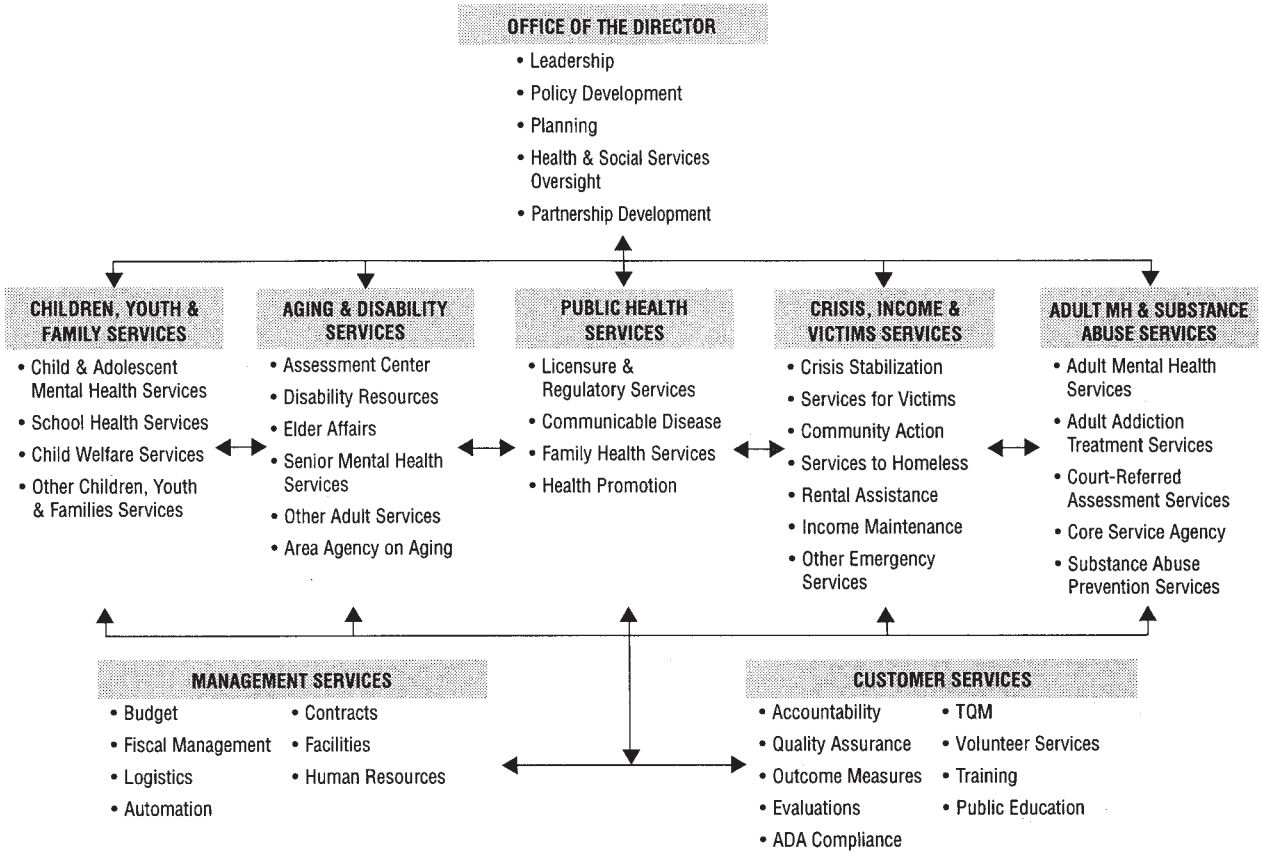

Montgomery County Department
of Health and Human Services

Measuring Progress

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Building a Safe, Healthy, and Self-Sufficient Community

WHY OUTCOMES?

As a community, we must make choices. What is most important to assure the well-being of county residents? How should resources be invested to achieve the greatest impact? How can the network of resources be brought together--government, civic organizations, the faith community, non-profit service providers and individuals--to improve and sustain the quality of life in Montgomery County?

Efficiency is important. Reducing costs and duplication is important. Making services accessible and responsive is important. We are seeking to achieve all of these. But most important, and often missing in the past, is knowing whether our efforts are making a difference in people's lives. If we are clear about our goals, and measure our progress, we can see more clearly if we are headed in the right direction. In the Department of Health and Human Services (DHHS), this is the path we have taken.

Community outcomes are the dreams and goals that Montgomery County residents have for their community. *Community indicators* give us a means to measure how well the community as a whole is moving in the direction of these goals. For example, if we want to have a community where older adults can maintain independence (our *outcome*), one possible means of measuring that would be whether senior citizens are able to live safely in the community, rather than in a nursing home (our *indicator*). Once we have agreed on our outcomes and indicators, we will have clear goals and measures of success. We can then look at the research about what works and set community-wide strategies based on that research. This process will help focus the entire community on achieving the goals most important to us all.

In addition to having a clear picture of how we are doing as a community, we must also examine how well we are using the county's resources for programs designed to achieve these goals. *Program measures* tell us how well a particular service is contributing to achieving the desired result for the people served by the program or initiative. For example, the department provides foster care and group home care for frail elderly persons. In the past, information was collected on how many *people* were placed, but there were no measures to determine whether the placements were successful. One measure of whether the program's goal *to provide a stable, protective living environment* for these individuals is being met is the percent of *clients* who remain safely in the foster care or group home six months after placement. This *program measure* differs from an *indicator* because its focus is on the people the department is attempting to help, which in this case is a subset of all seniors in the county.

This new results-based approach focuses on looking upward toward achieving an outcome and outward to establishing partnerships and alliances. It moves beyond simple program delivery to a focus on the fundamental results sought by all members of the community. For success, it will require each member of the community to take responsibility for achieving some aspect of the larger vision--and it will require strong and effective partnerships. By working together we will achieve greater results.

HOW DID WE ARRIVE AT OUR OUTCOMES?

In recognition of the need to reduce duplication and create accessible services for our residents, the Department of Health and Human Services was created in 1995, merging four formerly separate departments: Social Services, Health, Family Resources, and Addiction, Victim and Mental Health Services. Since its inception, the department has focused on improving the lives of county residents by assuring that all services are working in concert and programs are accountable for results.

Realizing that the quality of life in Montgomery County is dependent on government and community members working together, one of the first steps the department took was to invite community members to help determine how best to integrate public and private services. These service integration teams, drawn from a broad spectrum of people throughout the community, helped identify what they felt is most important to the well-being of the community. From this information, its was clear that three key outcomes were common to all: that people in Montgomery County want to be safe, healthy and self-sufficient.

The department then worked with the Collaboration Council for Children, Youth and Families and other groups to convene a work group of private citizens, community representatives and department staff. The work group chose the name *Montgomery Common Ground* to reflect its focus on issues of common concern to all of our residents. Using the initial three outcomes identified by the service integration teams as a foundation, they held focus groups, convened community meetings and met with opinion leaders and board and commission members to test the three key outcomes and to identify the 12 most important *community-wide outcomes* that contribute to a safe, healthy and self-sufficient community. Appropriate *indicators* were then selected that would serve as measures of community progress in achieving the outcomes.

Concurrently, the department began to set goals for its programs and initiatives, and to improve the methods of measuring its progress toward these goals, to assure that county resources are being directed toward achieving results. Toward this end, DHHS has chosen *program measures* to track selected efforts in each service area.

Measuring Progress

There is no one perfect measure. Often, more than one measure is needed to accurately identify trends, especially when measuring something as complex as human behavior. On the other hand, if too many measures are used, one may lose sight of the important outcomes we are seeking. This is not about changing measures, it is about changing lives. Whether we are measuring community effectiveness or program effectiveness, measures were selected based on these criteria:

- data availability;
- whether the measure communicates well to the general public; and
- whether it tends to move in concert with related measures.

If important data are not available, they are placed on a data agenda, so that priorities can be set for future data collection efforts.

COMMUNITY-WIDE OUTCOMES AND INDICATORS

Outcomes

The 12 outcomes that have been identified as priorities to assure the *safety*, *health*, and *self-sufficiency* of Montgomery County residents are listed below. Many are interrelated.

1. Safe Individuals and Families
2. Safe Communities
3. Healthy Children
4. Healthy Adults
5. Healthy Older Adults
6. Healthy Communities
7. Children Ready for School
8. Children Succeeding in School
9. Young People Making Smart Choices
10. Economically Secure Individuals and Families
11. Adults with Disabilities Participating in the Community
12. Older Adults Maintaining Independence

The outcome *Young People Making Smart Choices* was chosen by the County Executive's initiative *Montgomery Measures Up!* as the first multi-department effort of county government to improve the health and safety of our youth and to help them move toward self-sufficiency. This effort will encourage and support young people to make smart choices about school, substance abuse, and sexual and criminal behavior.

Indicators

Measurable *indicators* show us where Montgomery County stands on the path to successfully achieving these outcomes. For example, if the number of children who are abused goes down, or the number of seniors living safely and independently goes up, things appear to be on the right track. However, if the percent of children who are immunized goes down, or the percent of adults with disabilities who are employed in jobs that match their abilities declines, changes need to be made in the strategies being used to address these issues.

The outcomes and indicators[1] selected were chosen based on input from the community, the expertise of health and human service professionals, and the experience of other communities.

The section in this report on "Outcomes and Indicators" includes: 1) a summary list of the community outcomes and indicators and 2) specific information on each indicator selected, including:

- What the indicator measures;
- Why the indicator is important; and
- Where we are now.

[1] Indicators have not yet been selected for three outcomes: *Healthy Older Adults*, *Children Ready for School*, and *Children Succeeding in School*. Selecting the best quality of life indicators for *Healthy Older Adults* will require additional community discussion. Although DHHS does not have the lead on improving outcomes related to *Children Ready for School* and *Children Succeeding in School*, in the coming year the department hopes to work with Montgomery County Public Schools to select jointly appropriate indicators.

DHHS PROGRAM MEASURES

To determine whether community resources are achieving results, the department has selected a few key programs or initiatives for its initial effort to monitor progress.

The programs or initiatives selected are:

1. Adult addiction services
2. Adult mental health services
3. Adult protection services
4. Assisted living services
5. Child care subsidies
6. Foodborne diseases control
7. Partner abuse services
8. Services for abused and neglected children
9. Services for homeless individuals
10. Teen parent support services
11. Tuberculosis control
12. Vocational skills development
13. Welfare reform

The section in this report on "Program Measures" includes: 1) a summary list of measures for the above programs or initiatives and 2) specific information on each program measure including:

- A clear goal that ties specifically to at least one of the 12 community outcomes;
- Specific program measures that will permit tracking progress;
- When available, the data is displayed in a graph to identify any trends;
- An analysis that interprets the trends;
- Research information on approaches that work to achieve the result sought;
- Proposed strategies to achieve results;
- The lead program(s) and other DHHS programs that contribute to achieving the result;
- Other partners outside of DHHS whose contributions are critical to achieving the result.

NEXT STEPS

To further implement the new system of accountability, DHHS plans the following next steps:

Community Outcomes:

- Initiate community discussions to select indicators for the outcome *Healthy Older Adults.*
- Continue discussions with Montgomery County Public Schools to select indicators for the outcomes *Children Ready for School* and *Children Succeeding in School*.
- Continue to work with other county departments, agencies and the community on the County Executive's *Montgomery Measures Up!* initiative focusing on the outcome *Young People Making Smart Choices.*
- Combine forces with people working on initiatives related to health and human services to ensure that all parties work together to achieve community outcomes.
- Monitor community progress in achieving the outcomes and issue periodic community reports.

Program Measures:

- Monitor the department program measures selected this year, with special focus on the effectiveness of new strategies/initiatives.
- Develop measures for additional department programs and initiatives focusing particularly on the department's highest priorities.
- Issue periodic progress reports on program results.
- Use the outcomes, goals and program measures as a guide for developing next year's department budget.
- Provide technical support on outcomes through consultation and training for those involved with these efforts both within and outside government, giving special attention to our contractual partners.

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Montgomery County Department
of Health and Human Services

Measuring Progress

Community Outcomes and Indicators

"An outcome is the goal we seek as a community, a condition of well-being"

"An indicator is a measure of community well-being"

Health and Human Services
Outcomes and Indicators

☆ SAFE ☆

Safe Individuals and Families

- Incidence of child abuse and neglect
- Incidence of reported partner abuse
- Incidence of reported elder abuse and neglect
- Incidence of reported abuse of adults with disabilities
- Incidence of juveniles who run away from home

Safe Communities

- Percent of county residents who are crime victims
- Percent of seniors who have been victims of crime
- Rate of deaths from alcohol-related motor vehicle crashes

☆ HEALTHY ☆

Healthy Children

- Rate of low birth weight babies
- Rate of infant mortality
- Percent of immunized two-year old children

Healthy Adults

- Breast cancer mortality rate
- Lung cancer mortality rate

Healthy Older Adults

Indicators are being developed.

Healthy Communities

- Rate of active infection with tuberculosis
- Rate of reported cases of AIDS
- Rate of sexually transmitted diseases

☆ SELF-SUFFICIENT ☆

Children Ready for School

The department will work with Montgomery County Public Schools to select appropriate indicators.

Children Succeeding in School

The department will work with Montgomery County Public Schools to select appropriate indicators.

Young People Making Smart Choices

- Rate of births to teen mothers
- Percent of eighth graders who smoke cigarettes
- Percent of eighth graders who use marijuana
- Percent of tenth graders who engage in binge drinking
- Rate of juvenile arrests for nonviolent crimes
- Rate of juvenile arrests for violent crimes

The department will work with Montgomery County Public Schools to develop appropriate education indicators for this outcome.

Economically Secure Individuals and Families

- Percent of children living in poverty
- Welfare rate

Adults with Disabilities Participating in the Community

- Percent of youths with disabilities who get jobs or go to college after high school graduation
- Percent of adults with disabilities living in nursing homes

Older Adults Maintaining Independence

- Percent of seniors living in nursing homes

Montgomery County Department
of Health and Human Services

Key Community Outcome: SAFE

Major Outcome:
SAFE INDIVIDUALS AND FAMILIES

Major Outcome:
SAFE COMMUNITIES

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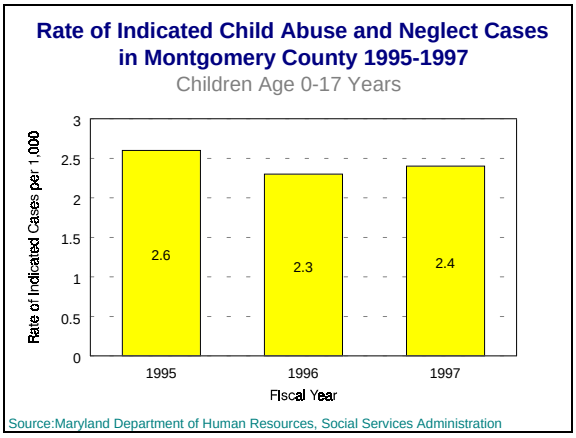
OUTCOME: Safe Individuals and Families

INDICATOR: Incidence Of Child Abuse And Neglect



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of cases where abuse or neglect was indicated. When the Montgomery County Department of Health and Human Services receives a report of suspected child abuse or neglect, it must determine if an investigation is warranted. Historically, about 30% to 40% of all reports are determined to require investigation. Data on the number of cases that are considered "indicated" are displayed for FY95 through FY97. These are the cases where there is sufficient evidence to determine that a child was abused or neglected.

Although the data being tracked do not give us exact numbers of abused and neglected children in Montgomery County, they do give a clear picture of trends in child maltreatment. It is important to note that since indicated investigations are per family, and more than one child in the family can be involved, the rates may be higher than the data shows. Several national studies of family violence and child maltreatment have also found that, even with mandatory reporting, child abuse and neglect may be underreported by as much as 44%.

WHY IS THIS INDICATOR IMPORTANT?

The protection of children from maltreatment is one of the most grave responsibilities shared by the government and community. The incidence of child abuse and neglect reflects the degree to which children in our community are safe and whether community supports are in place to deter child maltreatment. Reported cases of child maltreatment have been increasing nationally, and in Montgomery County the incidence of abuse and neglect increased 30% in FY 97. In 1997, there were several highly publicized child abuse cases, not only in Montgomery County but also in the surrounding jurisdictions, which resulted in a 44% increase in referrals to protective services in Montgomery County.

Child abuse or neglect can result in physical harm, profound developmental and behavioral problems or even death. Disabled children are at special risk and are maltreated almost twice as often as other children. Victims and perpetrators of child abuse and neglect are found in all classes and races. Abuse or neglect often stems from various stresses upon the family, such as parental alcoholism, absence of a parent, unemployment, drug abuse or domestic violence. National studies also show a correlation with family economic levels. Families with low incomes (less than $15,000 per year), have 25 times higher rates of abuse and 44 times higher rates of neglect than families with higher incomes (at or above $30,000 per year).

Abused and neglected children are at greater risk of becoming involved in delinquent behavior and mistreating their own children when they become parents. Physical and sexual abuse are correlated with violent behavior in later life, suicide, running away, drug abuse, alcoholism and teen pregnancy. Abuse is also associated with lower functional IQ scores, learning disabilities, attention problems, low self-esteem, and long-term health and mental health problems.

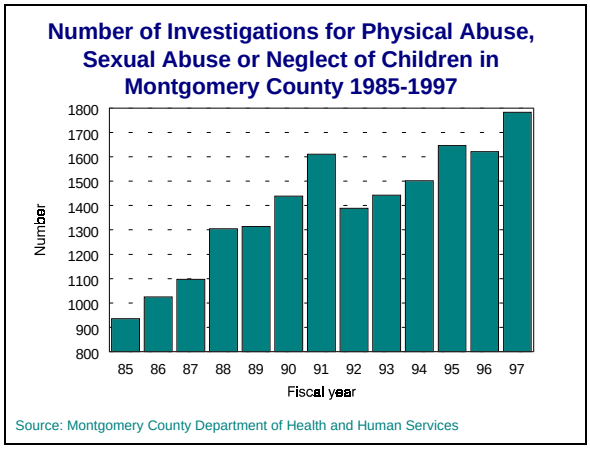
When abused and neglected children cannot remain safely with their families, they may require placement with relatives or a foster family. Children are entering out-of-home care at a younger age and with more serious problems, resulting from physical, sexual or emotional abuse, alcohol or drug exposure, poverty and homelessness.

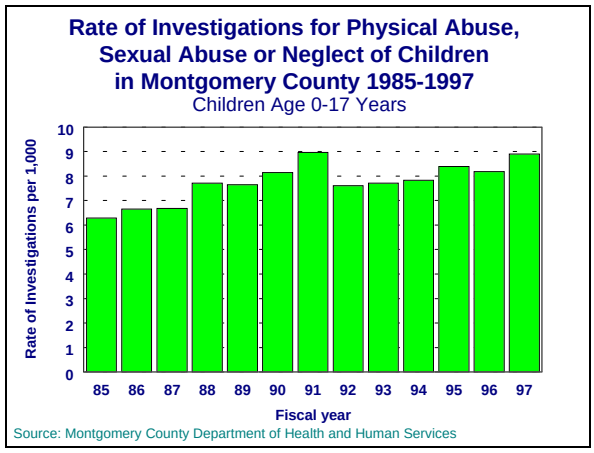
WHERE ARE WE NOW?

Rate of indicated child abuse and neglect cases:

- The rate of indicated cases in the county has remained fairly consistent for the past three years: 2.6 in FY95, 2.3 in FY96 and 2.4 in FY97.
- In FY95, of 1,646 investigations conducted, 30% were found to be "indicated."
- In FY97, of 1,782 investigations, 27% were indicated as abuse or neglect.
- In FY96 Montgomery County had the lowest rate of indicated cases of any county in Maryland, 2.3 per 1,000 children, compared to the statewide rate of 7.2 per 1,000 children.

Number and Rate of Investigations:





While the rate of indicated cases has remained fairly constant, the number and rate of investigations has been increasing.

- After a period of some stability in the early 1980s, the rate of investigations rose steadily from 6.3 per 1,000 children in 1985 to a high of 8.9 per 1,000 in FY91.
- This rate increase in FY91 is consistent with a nationwide increase in investigations for maltreatment of children from 1990 to 1992.
- After dropping to 7.6 per 1,000 children in FY92, the rate has now climbed back up to 8.9 per 1,000.
- In FY96, Montgomery County had an investigation rate of 8.2 per 1,000 children, compared to approximately 23 per 1,000 children statewide. Montgomery County has had a lower rate of investigations than other Maryland jurisdictions.
- In FY97, DHHS conducted 1,782 investigations, a rate of 8.9 per 1,000 children. There were 803 investigations for physical abuse, 661 for child neglect and 318 for sexual abuse.

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National Clearing House On Child Abuse And Neglect Information: nccanch@calib.com.

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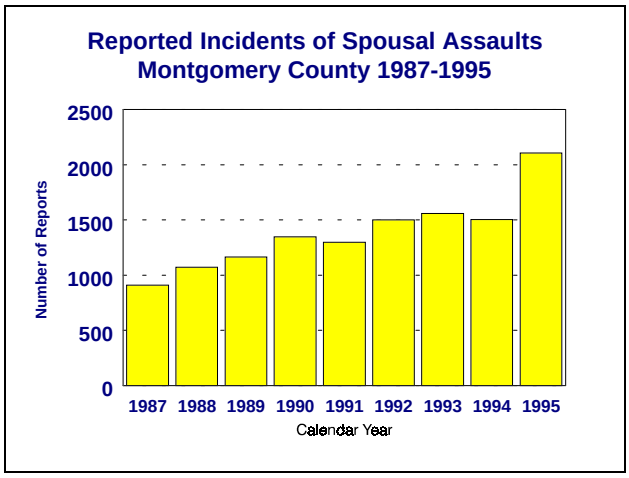
Starting Points in Maryland, Ready at Five Partnership, 300 Cathedral Street, Suite 500, Baltimore, Maryland 21201, January 1996.

The Third National Incidence Study of Child Abuse and Neglect (NIS-3), US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect, September 1996.

Violence in Families: Assessing Prevention and Treatment Programs, Chalk, R., & King, P. , eds. Washington, DC: National Academy Press, 1998.

OUTCOME: Safe Individuals and Families

INDICATOR: Incidence Of Reported Partner Abuse



WHAT DOES THIS INDICATOR MEASURE?

This indicator, based on comprehensive data gathered by the Maryland State Police, tracks the number of spouse abuse reports made to any police authority in Montgomery County, including the Montgomery County Police Department, Takoma Park Police Department, the Sheriff's Office, and the U.S. Park Service Police.

The most recent year figures are available is 1995. Prior to 1996 police reported "spousal assault" incidents, which were defined as assaults involving heterosexual partners who were or who had been living together, but were not necessarily married. In most cases (about 85%), the victim was a woman, and the majority of victims (61% in 1995) suffered injuries. Since then, this crime has been redefined as "domestic violence" and expanded to include homosexual partners as well as acts of vandalism against the other partner.

WHY IS THIS INDICATOR IMPORTANT?

Spouse abuse is a strong measure of family dysfunction and is also strongly correlated with child abuse. One Oregon study revealed that evidence of spouse abuse is almost always found in cases involving a child abuse fatality and in 70% of all child abuse cases. Children who witness spouse abuse frequently exhibit this behavior themselves in later life. Studies conducted by the Office of Alcohol and Drug Abuse Programs show that 50% of all spousal assaults involve alcohol.

Research has shown that most women who report spouse abuse to the police do so only after a long pattern of abuse. Each year, spouse abuse results in about 4,000 homicides in the United States, and is one of the leading causes of injury to women. It has been estimated that over 50% of homeless women and children are in flight from abusive spouses. Spouse abuse also involves expenditures of public funds. Although expenditures related to spouse abuse in Montgomery County are not available, New York City estimates that it spends $30 to $40 million a year caring for such persons in homeless shelters and another $71.5 million paying foster care costs for the children of abused mothers. Domestic abuse also results in increased medical costs. While information is not available locally, Chicago's St. Luke's Medical Center estimated the direct medical costs for spouse abuse-related injuries at $1,633 per case. Police department expenditures must also be considered. Researchers have estimated that domestic

violence calls were the most frequent calls made to police departments and that 33% to 40% of all police time was used to respond to them. New York City estimated an average cost of $3,241 for each domestic violence arrest in 1989.

WHERE ARE WE NOW?

Reports of spouse abuse submitted by the Montgomery County Police Department (MCPD) and county municipal police departments to Maryland State Police have increased from 909 reports in 1987 to 2,107 reports in 1995. Between 1994 and 1995, reports increased 40 percent. This big increase may be attributable to the publicity surrounding the 1994-95 O.J. Simpson trial as well as to state legislation passed in 1992 and 1994 that significantly expanded the assistance and protection available to victims of spouse abuse.

More recent, though less comprehensive, data compiled locally by MCPD reveal a 134% increase in spouse abuse reports between 1995 and 1996--from 1,591 to 3,718. Sgt. Diane McCarthy, Domestic Violence Unit, MCPD, believes the increase may be due, in large part, to a new state law that went into effect in January 1996, requiring police officers on the scene to write up a spousal assault report anytime this crime is alleged to have happened, regardless of how the case is settled. Prior to the new law, police did not write a report if the situation was remedied at the scene. The increase is most likely due to increased reporting.

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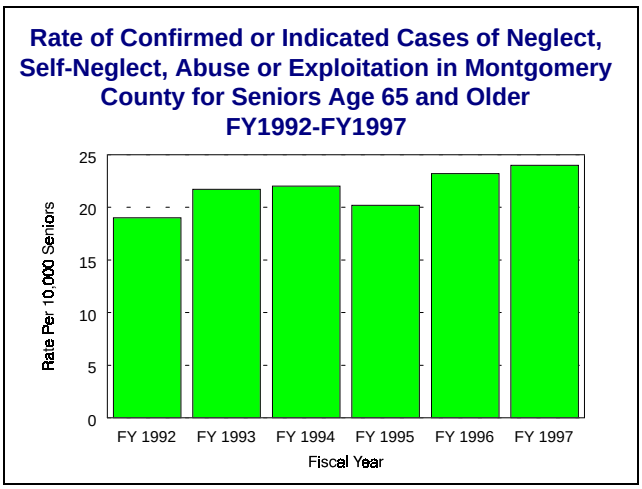
OUTCOME: Safe Individuals and Families

INDICATOR: Incidence of Reported Elder Abuse and Neglect



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate per 10,000 county residents age 65 and older who were reported to Adult Protective Services and were found to have suffered abuse, neglect, self-neglect or exploitation.

WHY IS THIS INDICATOR IMPORTANT?

The Maryland Adult Protective Services Law requires "each health practitioner, police officer, or human service worker who contacts, examines, attends, or treats an alleged vulnerable adult, and who has reason to believe that the alleged vulnerable adult has been subjected to abuse, neglect, or exploitation [to] notify the County Department of Health and Human Services as soon as possible."

Nationwide, in 1994, 41.9% of substantiated elder abuse cases were self-neglect while 52.5% were abuse by others. In cases of abuse by others, the victims are often helpless or unable to ask for help. In either case, persons 85 years or older are the most vulnerable group.

Self-neglect usually occurs in older, mentally disabled persons living alone who are no longer capable of independent living. In Montgomery County, for fiscal year 1997, more than three-fourths, or 77%, of confirmed cases were self-neglect. There has been little research on the subject of elder self-neglect despite the prevalence of confirmed cases. In fact, the first national forum on elder abuse, the House Select Committee on Aging, Subcommittee on Health and Long-Term Care, in 1978 hardly mentioned self-neglect. Additionally, data collected by various state Adult Protective Services agencies use different measures which are often not comparable. Many states do not make the distinction between self-neglect and neglect by others according to the National Association of Adult Protective Service Administrators. One study of data collected by the Tennessee Department of Human Services estimated that one-half of all referrals and about 70% of all confirmed cases were self-neglect.

WHERE ARE WE NOW?

The true prevalence of elder abuse cannot be captured in available data since it is highly under-reported. In fact, some experts estimate that only 1 in 14 abuse-by-others cases is actually reported to authorities. However, available data do give an indication of trends in prevalence. In fiscal year 1997, Montgomery County's Adult Protective Services investigated 312 cases, and abuse, neglect and/or exploitation was confirmed or strongly indicated in 218 cases. Since fiscal year 1992, the rate of abuse and neglect per 10,000 residents age 65 and older has increased from 19.0 to 24.0. The increase reflects changes seen nationwide. According to the 1994 National Center on Elder Abuse Report, reporting of elder abuse has steadily increased by 106% since 1986.

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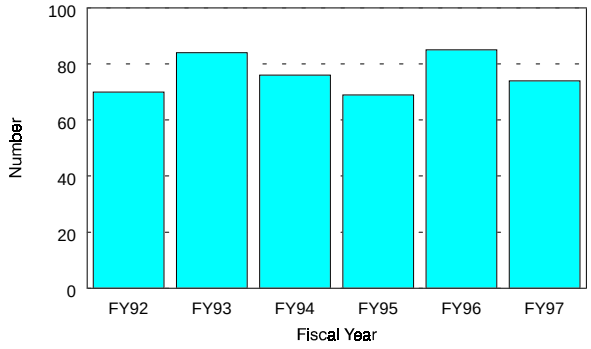
OUTCOME: Safe Individuals and Families

INDICATOR: Incidence Of Reported Abuse Of Adults With Disabilities

Number of Confirmed or Indicated Cases of Neglect, Self-Neglect, Abuse or Exploitation in Montgomery County for Adults with Disabilities, 1992-1997



Source: Montgomery County Department of Health and Human Services, Adult Protective Services

WHAT DOES THIS INDICATOR MEASURE?

This indicator measures the number of disabled adults age 18 to 64 years who were reported to Adult Protective Services and found, upon investigation, to have suffered abuse, neglect, self-neglect or exploitation. This number is not expressed as a rate because there are no reliable historical *yearly* estimates of the number of disabled adults age 18-64 residing in Montgomery County. The number of disabled adults residing in Montgomery County is only collected by the U.S. Census in decade increments.

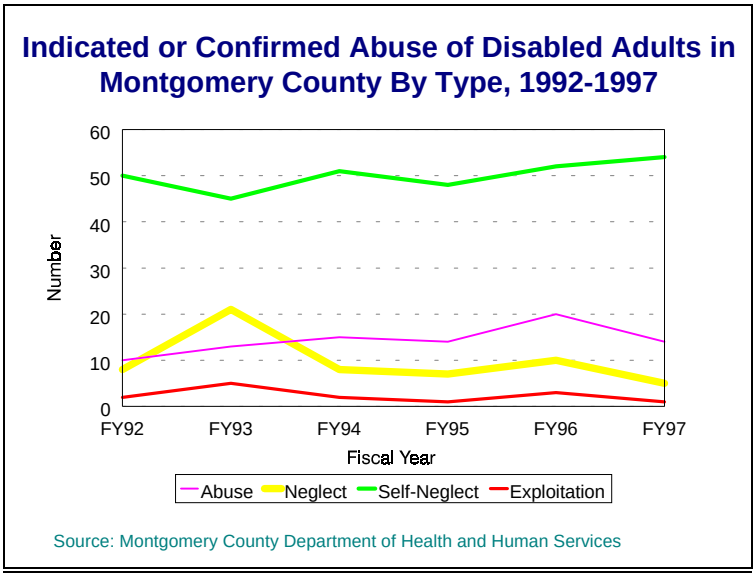
WHY IS THIS INDICATOR IMPORTANT?

Maryland Adult Protective Services Law requires "each health practitioner, police officer, or human service worker who contacts, examines, attends, or treats an alleged vulnerable adult, and who has reason to believe that the alleged vulnerable adult has been subjected to abuse, neglect, or exploitation to notify the County Department of Health and Human Services as soon as possible."

Adults with disabilities are at high risk of self-neglect due to the nature of their disability, premature aging, insufficient training for independent living, inappropriate institutionalization, and the aging or death of caregivers. Abuse, neglect or exploitation threaten the health, safety and welfare of disabled adults, who are especially vulnerable to maltreatment of this sort because they often have a difficult time escaping from or reporting the abuse. The individual may be financially dependent on the perpetrator or may not have the physical means to flee. There are few studies that examine abuse in this population.

WHERE ARE WE NOW?

Over the past six years the number of cases of abused or neglected adults with disabilities has fluctuated between 69 and 85, with no clear pattern of increase or decline. Consistently, the majority of Adult Protective Service cases are self-neglect. In FY97, Adult Protective Services conducted 122 investigations and identified 74 as cases where abuse or neglect was confirmed or strongly indicated. Most of these cases, 54, or 73%, involved self-neglect. Abuse was confirmed or indicated in 13, or 18% of the cases. Neglect was found in 5, or 7%. Exploitation was indicated in one case.



SOURCES

Adult Protective Services, Montgomery County Department of Health and Human Services.

MD-National Capital Park and Planning, Montgomery County Regional Office, Publications and Information.

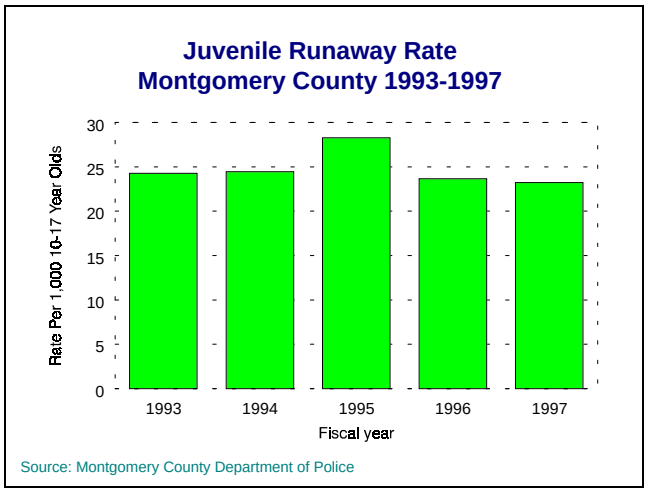
Rathbone-McCaun, E. & Fabian, D., Self-Neglecting Elders, 1992.

White, Natalie, Society Must Realize That Disabled Are Abused, Too. *The Standard-Times On-Line.* May 29. 1995. http://www.st.com/projects/DomVio/societymust.HTML.

Working Against Violence in Our Community Website: http://www.vaxxine.com/nrpsweb/disabled.htm.

OUTCOME: Safe Individuals and Families

INDICATOR: Incidence Of Juveniles Who Run Away From Home



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of juveniles (ages 10-17) reported to the Montgomery County Police Department as having run away. The figures include all municipal police departments, except Takoma Park. According to the police, many runaways return to their families within 24 to 48 hours; and most seek shelter at the home of a friend or relative. Locally, the median age of runaways is 15, but the age of runaways has been dropping--about 25% of the cases in recent years have been under 13 years-old.

WHY IS THIS INDICATOR IMPORTANT?

This is an important indicator of family problems. According to the Montgomery County Police Department's Youth Services Division, the county has been averaging about seven runaways a day. Parents, police and runaways themselves are saying that teenagers are facing enormous pressures today. Some arise from the normal difficulties of adolescence; others arise from more serious problems like physical, emotional or sexual abuse by a relative or family friend, family stresses stemming from divorce, or teenage pregnancy. Parents of runaways often complain that they cannot control these children, but the runaways themselves often say that their parents are "too strict." Running away from home often increases the child's exposure to drugs, alcohol, sexual assault or other forms of violence, and is also linked to the commission of crimes such as shoplifting and drug use. Police occasionally arrest juveniles reported missing by their parents if they refuse to return home voluntarily.

WHERE ARE WE NOW?

In FY97, 1,927 Montgomery County juveniles were reported to the police as runaways. In FY97 the runaway rate was 23 per 1,000 juveniles ages 10 to 17 years. Excepting the high of 28.3 reached in FY95, runaway rates in recent years have remained within a fairly narrow range of 23.2 to 24.4 per 1,000. We are unable to compare Montgomery County to other jurisdictions since statewide data are collected only on the small number of juveniles who are arrested after they refuse to return home.

In 1991 the Montgomery County Department of Police formed a partnership with Potomac Ridge Treatment Center, a private psychiatric hospital in Rockville, and started a new program called Operation Runaway. This program provides free, separate counseling sessions to runaways and their parents on a 24-hour basis. Most of the runaways picked up by the police are diverted into this program to prevent further occurrences rather than being arrested.

SOURCES

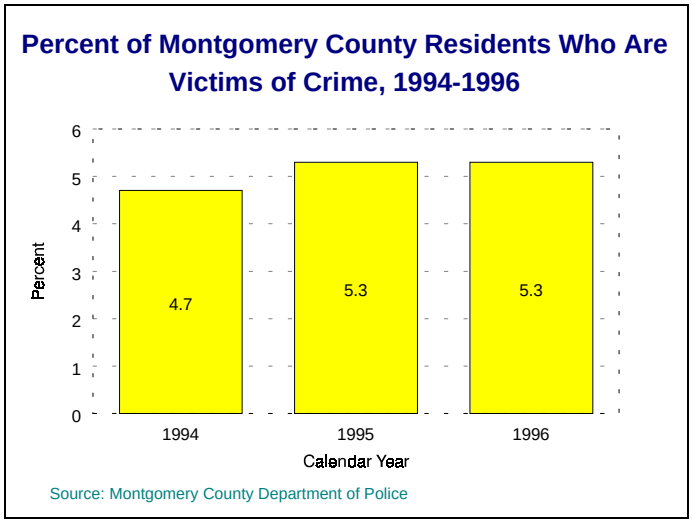
Maryland-National Capital Park and Planning Commission.

Montgomery County Department of Police , Records Division.

Montgomery County Department of Police, Lt. Frank Young, Youth Division.

OUTCOME: Safe Communities

INDICATOR: Percent Of County Residents Who Are Victims of Crime



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of Montgomery County residents who are victims of crime, based on statistics collected for the past three years by the Montgomery County Department of Police (MCPD). County police data do not include reports from the Takoma Park police, the M-NCPPC police or the Sheriff's Office, nor do they distinguish victims who are county residents from victims who reside elsewhere. Crimes are also underreported; the U.S. Department of Justice estimates that only 40% of crimes are actually reported. The data include all crimes except controlled substance violations, gambling offenses and disorderly conduct, as no victims are identified for these crimes.

WHY IS THIS INDICATOR IMPORTANT?

This is an important indicator of safety in a community. For Montgomery County, these facts are very different from perceptions of danger, which are often based on news stories from other parts of the Washington area.

WHERE ARE WE NOW?

From 1994 to 1996 the county population increased from 797,840 to 818,999 residents. The number and percent reported as victims of crimes increased from 37,446 (4.7%) in 1994 to 43,697 (5.3%) in 1996.

Victims of violent crimes represent 4.4% of total victims. Of the total 43,697 victims reported in 1996, there were 13 murder victims, 154 rape victims, 1,016 aggravated assault victims and 728 robbery victims. The largest percentage were victims of nonviolent crimes, with the largest percentage of these being victims of larceny (39.0%), followed by simple assault (16.8%), vandalism (12.4%), burglary (6.5%), auto theft (6.5%), juvenile offenses (4.4%), and sex offenses (1.2%).

SOURCES

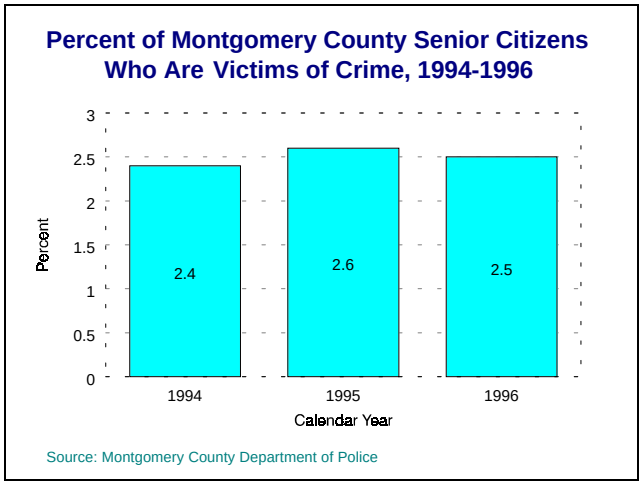
Maryland-National Park and Planning Commission.

Montgomery County Department of Police, Records Division.

U.S. Department of Justice, National Crime Victimization Survey.

OUTCOME: Safe Communities

INDICATOR: Percent Of Senior Citizens Who Have Been Victims Of Crime



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the total number of senior citizens, age 61 or older, who were victims of crime in Montgomery County. The data, available only from 1994-96 from the Montgomery County Department of Police, does not include crimes reported by Takoma Park police, the M-NCPPC police, or the Sheriff's Office. The statistics do not distinguish between victims who are county residents from victims who reside elsewhere. Crimes are also underreported; the U.S. Department of Justice estimates that only 40% of crimes are actually reported. The data include all crimes except controlled substances violations, gambling and disorderly conduct offenses, as no victims are identified for these crimes. These figures are considered an under-count of the crimes actually committed since many crimes are not reported to the police.

WHY IS THIS INDICATOR IMPORTANT?

Senior citizens, particularly frail or disabled seniors, would appear to present a more vulnerable target for crimes, such as theft, robbery, rape, assault, vandalism or fraud; and sensational news stories often inflate people's fears beyond what the facts actually show. For this reason, it is important to document the actual percentage of Montgomery County senior citizens who are victims of crime. Information on seniors' perception of the frequency of crime is not available.

WHERE ARE WE NOW?

In Montgomery County 2.4% of senior citizens were reported to be victims of crime in 1994, 2.6% in 1995 and 2.5% in 1996.

For senior citizens, victims of violent crimes represented 2.3% of the total victims in 1996. Of the 2,857 seniors who were victims of crime that year, there were 2 murder victims, 1 rape victim, 12 aggravated assault victims, and 51 robbery victims. The largest percentage were victims of nonviolent crimes, with the largest being victims of larceny (45.3%), followed by vandalism (19.7%), burglary (12.3%), automobile theft (7.8%), simple assault (4.2%), forgery (1.1%), embezzlement (0.9%), and arson (0.5%).

SOURCES

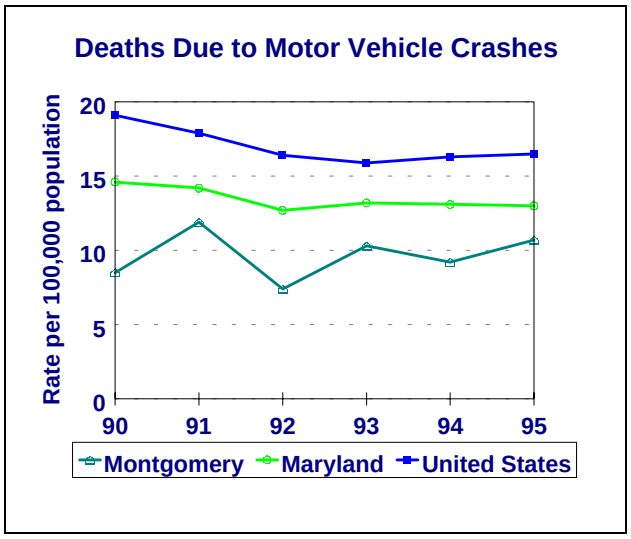
Maryland-National Park and Planning Commission.

Montgomery County Department of Police, Records Division.

U.S. Department of Justice, National Crime Victimization Survey.

OUTCOME: Safe Communities

INDICATOR: Rate Of Deaths From Alcohol-Related Motor Vehicle Crashes



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the death rate from alcohol-related motor vehicle crashes per 100,000 population.

WHY IS THIS INDICATOR IMPORTANT?

More than 17,450 Americans died in alcohol-related motor vehicle crashes in 1995 (the latest year figures are available), accounting for 44% of all traffic fatalities that year. One-third of these victims were under the age of 25. Motor vehicle crashes have a far reaching impact on all citizens, not only from injuries and death, but in economic terms as well. Alcohol-related motor vehicle crashes cost the nation at least $46 billion a year.

WHERE ARE WE NOW?

Montgomery County is below the state and national average. In 1995, 37 deaths in Montgomery County were attributed to alcohol-related motor vehicle crashes. This represents fully 43% of all motor vehicle-related deaths in the county.

A variety of organizations are involved in activities to reduce drunk driving. The police departments conduct sobriety road checks, educate school children about the dangers of alcohol and other drugs, and talk about the dangers of drinking and driving on the radio and on television. Mothers Against Drunk Driving (MADD) has helped advocate for legislation that reduces drunk driving and its student groups, Students Against Destructive Decisions (SADD), formerly known as Students Against Drunk Driving, work with students to discourage underage alcohol consumption. To reduce underage drinking, Drawing the Line, a public/private collaboration, works to discourage underage drinking and to enforce the prohibition of alcohol sales to minors. To provide teens with alternatives to week-end activities that involve alcohol, the Department of Recreation sponsors alcohol-free events. These are only a few of the many activities in the community to reduce drunk driving.

Alcohol is the most commonly used and abused substance. Concerted efforts to reduce alcohol abuse--especially among teenagers--are needed, including education, enforcement and legislation, to reduce this preventable cause of injury and death.

SOURCES

Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

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Montgomery County Department
of Health and Human Services

Key Community Outcome: HEALTHY

Major Outcome: HEALTHY CHILDREN

Major Outcome: HEALTHY ADULTS

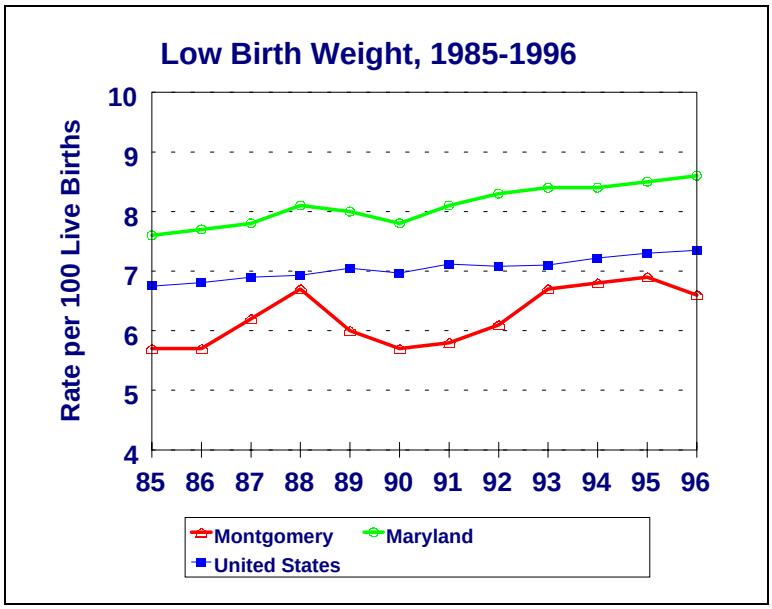
Major Outcome: HEALTHY OLDER ADULTS

- Indicators are being developed.

Major Outcome: HEALTHY COMMUNITIES

OUTCOME: Healthy Children

INDICATOR: Rate Of Low Birth Weight Babies



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of birth of low weight babies per 100 live births. A low birth weight (LBW) baby is defined as a baby who weighs less than 5.5 pounds (2,500 grams) at birth.

WHY IS THIS INDICATOR IMPORTANT?

Low birth weight is associated with a poor pregnancy outcome for both the baby and the mother. The majority of problems affecting newborns are related to prematurity; the earlier in gestation an infant is born, the greater the risk. LBW has a variety of causes, such as inadequate prenatal care and poor nutrition. Maternal smoking is associated with a slight decrease in birth weight. A mother's low socioeconomic status is also linked to her probability of having a low birth weight baby. However, any woman who fails to get good prenatal care--regardless of her socioeconomic status--is at greater risk for having a low birth weight baby.

WHERE ARE WE NOW?

As many as 7.3 percent of babies born in the United States are LBW babies. About 6 percent of babies born of Montgomery County residents are classified as LBW babies. There has been a slight increasing trend of LBW babies in the county in the past ten years. In light of decreasing infant mortality, many researchers attribute this phenomenon to the ability to use advanced technologies to sucessfully care for high-risk infants. Much of the morbidity due to low birth weight can be prevented through good prenatal care.

SOURCES:

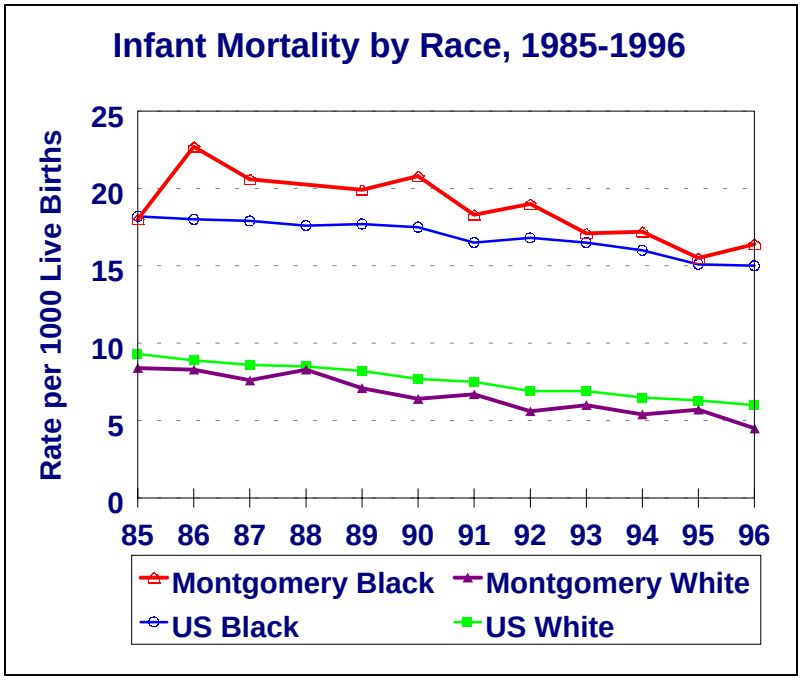
Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

OUTCOME: Healthy Children

INDICATOR: Rate Of Infant Mortality



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the death rate of infants per 1,000 live births. Infants are defined as babies from birth to one year of age. The infant mortality rate is a standard index of health. In 1991 the United States' infant mortality rate ranked 24th among all nations. At the same time, the U.S. spent more per capita and a larger percentage of its GNP on health care than any other nation.

WHY IS THIS INDICATOR IMPORTANT?

Infant mortality reflects many contributing factors, such as socioeconomic status, maternal health status, adequacy of prenatal care and utilization of health care resources. Low birth weight is the most important factor associated with infant mortality and much of it is preventable through early and comprehensive prenatal care.

WHERE ARE WE NOW?

The infant mortality rate in Montgomery County has been gradually decreasing and in 1996 was 6.6 per 1,000 live births. This is slightly below the *Healthy People 2000* (the national strategy for improving the health of the nation by addressing the prevention of major chronic illnesses, injuries and infectious diseases) goal of seven deaths. Although the overall trend is encouraging, differences persist in race-specific rates. Infant mortality rates for African-American babies in both Montgomery County and the U.S. are almost three times as high as for white babies.

SOURCES:

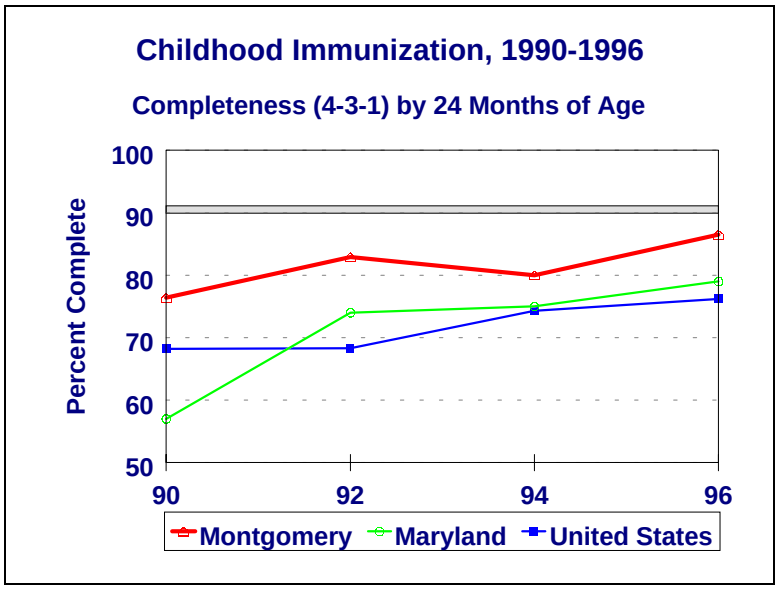
Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

OUTCOME: Healthy Children

INDICATOR: Percent Of Immunized Two-Year Old Children



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the completeness of immunizations among two year-olds. Completeness of immunization status is referred to as 4-3-1 since by age two a child should have received at least four (4) doses of diphtheria, tetanus and pertussis vaccine, three (3) doses of polio vaccine, and one (1) dose of measles, mumps and rubella vaccine. Statistics are derived from the Maryland Department of Health and Mental Hygiene's annual Two-Year-Old Immunization Survey.

WHY IS THIS INDICATOR IMPORTANT?

Vaccines protect children against highly contagious illnesses, such as mumps, whooping cough and polio. In 1954, the year immunization against polio began, Centers for Disease Control and Prevention (CDC) reported 38,476 cases of polio and 682,720 cases of measles. Forty years later CDC reported two cases of polio and 309 cases of measles. These dramatic decreases are the direct results of the development of vaccines and immunization efforts.

WHERE ARE WE NOW?

In Montgomery County, the immunization status of two-year-old children who had received at least four doses of diphtheria, tetanus and pertussis vaccine, three doses of polio vaccine, and one dose of measles, mumps and rubella vaccine rose from 76% percent in 1990 to 86% in 1996. In comparison, in Maryland the rate rose from 57% in 1990 to 79% in 1996. The *Healthy People 2000* (the national strategy for improving the health of the nation by addressing the prevention of major chronic illnesses, injuries and infectious diseases) goal is 90% and Montgomery County is within striking distance. Considerable effort to identify and overcome barriers (such as transportation, language, money, time, understanding the need for and/or valuing vaccines) that interfere with the on-time receipt of immunization have paid off in Montgomery County.

The department has made efforts to overcome the language barrier and to increase the understanding of the need for vaccination by outreach to multicultural communities and translation of brochures into both Spanish and Vietnamese. Community involvement in this endeavor has also been a factor. Transportation is available through a private-public partnership with the Rotary Club. A private-public partnership with Adventist HealthCare has been established to overcome the concerns about time. It is often difficult for working parents to get off of work in order to get their children vaccinated. As a result of this partnership, parents are able to obtain free vaccinations for their children at Adventist Hospitals on the first Saturday morning of every month on a walk-in basis. Continued vigilance on the part of the department and the community will help us to reach the national goal for the year 2000.

SOURCES:

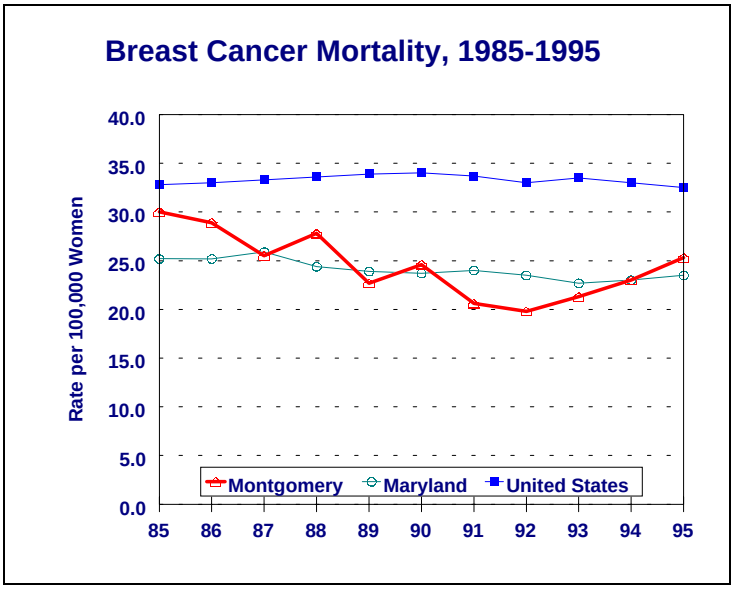
Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

OUTCOME: Healthy Adults

INDICATOR: Breast Cancer Mortality Rate



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the death rate due to breast cancer per 100,000 women.

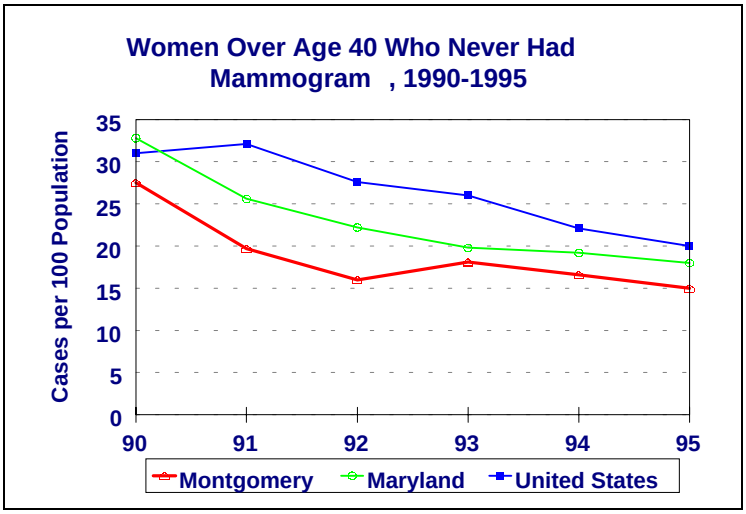
WHY IS THIS INDICATOR IMPORTANT?

In 1996, an estimated 184,300 new cases of breast cancer were diagnosed and an estimated 44,300 people died from the disease in the United States. The risk of developing breast cancer increases with age; and those with a family history of breast cancer, or who never had children or had their first child after age 30, are at increased risk. Breast cancer, the number two cause of cancer deaths in women, cannot be prevented. However, it is treatable if detected at an early stage.

WHERE ARE WE NOW?

The death rate from breast cancer has been declining gradually during the past decade. More and more women, however, are diagnosed with breast cancer. One out of nine women in the U.S. will develop breast cancer in her lifetime. African-American women appear to have high breast cancer fatality rates. In Montgomery County, breast cancer is the second leading cause of death among African-American women.

Early diagnosis through screening is the key to reducing breast cancer mortality. Monthly breast self-exam should be an essential component of each woman's health habits. Most experts agree that the increasing use of mammography is a major reason for declines in death rates while case rates increase. In Montgomery County the rate of women over age forty who have never had a mammogram has decreased from 27.5 in 1990 to 15 in 1995.



SOURCES:

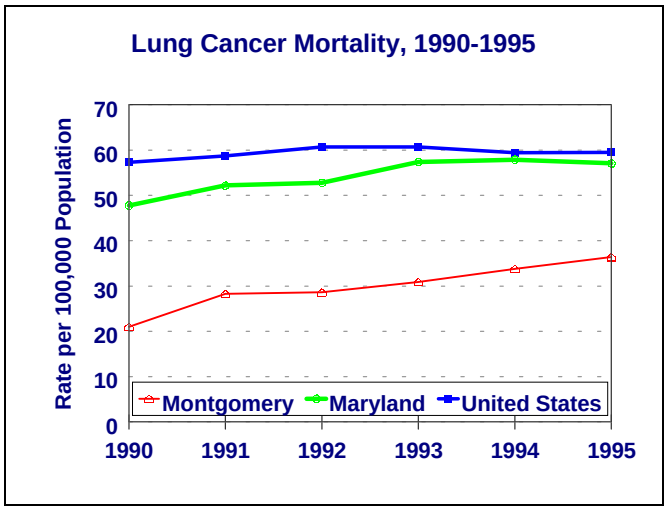
Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

OUTCOME: Healthy Adults

INDICATOR: Lung Cancer Mortality Rate



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the lung cancer death rate per 100,000 population.

WHY IS THIS INDICATOR IMPORTANT?

Lung cancer is the leading cause of cancer deaths in the United States. Lung cancer killed 2,984 people in Maryland in 1995. Smoking causes at least 80 percent of lung cancer deaths, and secondhand smoke is a known cause of lung cancer among non-smokers. Preventing and reducing tobacco addiction will reduce lung cancer deaths.

WHERE ARE WE NOW?

While overall death rates have been declining, deaths due to lung cancer have been slowly increasing in Montgomery County in the past decade. This trend is expected to continue, in light of rising teen smoking. In 1995, 295 Montgomery County residents died from lung cancer. Lung cancer kills more women than breast cancer each year.

Since smoking has been strongly associated with lung cancer, much of lung cancer is preventable by reductions in smoking. Young people should be targeted for anti-smoking education because 90 percent of adult smokers began smoking during their teen years.

SOURCES:

Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

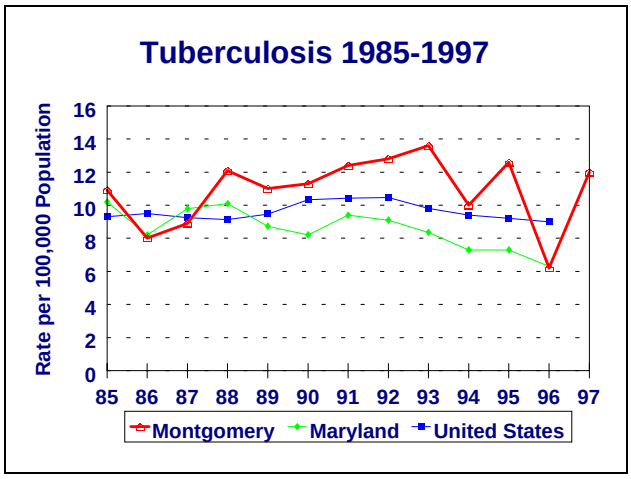
Maryland Cancer Registry.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

OUTCOME: Healthy Communities

INDICATOR: Rate Of Active Infection With Tuberculosis



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of active infection with tuberculosis (TB) per 100,000 population.

WHY IS THIS INDICATOR IMPORTANT?

Since the mid-1980s, there has been a substantial increase in TB cases in the United States. There are many reasons for this increase, including HIV, overcrowded living conditions, immigration from countries with a high prevalence of TB, and reduced resources available for TB control. Treatment for active cases takes from six months to more than a year, particularly if the person has HIV or harbors multi-drug resistant TB, which makes it more difficult and expensive to treat.

WHERE ARE WE NOW?

The case rate in Montgomery County reached a high of 14 per 100,000 population in 1993. In 1996, the rate decreased to 6.2 per 100,000. The wide fluctuations in cases in the county may be due to variations in patterns of influx of immigrants from countries where tuberculosis is more prevalent. The decline of TB cases since 1993 is at least partially due to the effectiveness of directly observed therapy (DOT), which involves the in-person administration of TB drugs.

SOURCES:

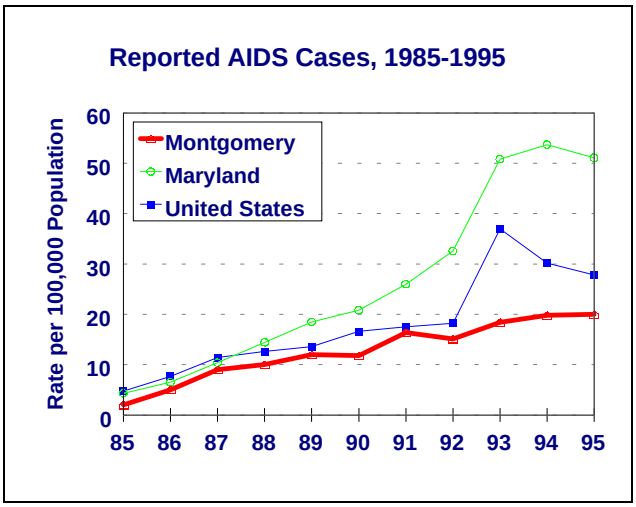
Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

Maryland Department of Health and Mental Hygiene, Center for Health Statistics.

Montgomery County Department of Health and Human Services, Public Health Services.

OUTCOME: Healthy Communities

INDICATOR: Rate Of Reported Cases Of AIDS



WHAT DOES THIS INDICATOR MEASURE?

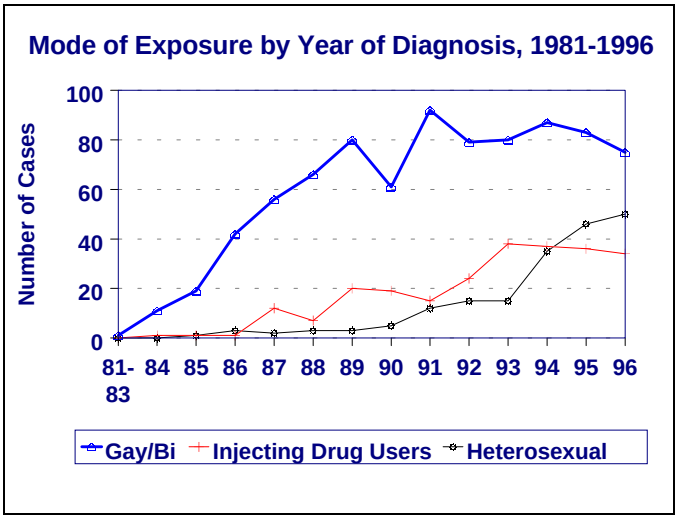
This indicator tracks the incidence of reported cases of AIDS per 100,000 population.

WHY IS THIS INDICATOR IMPORTANT?

Nationally, about 1.5 million people are infected with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS). More than half a million Americans have been diagnosed with AIDS. AIDS results in progressive damage to the immune system which, in turn, allows opportunistic infections. It is transmitted sexually, by exposure to infected blood or from infected mothers to their fetuses. It is a major public health concern, one that is costly to the health care system.

WHERE ARE WE NOW?

In 1997, there were 187 new cases of AIDS reported in Montgomery County. Although the overall case rates are declining, new cases of AIDS are rising rapidly among women, injecting drug users (IDU) and African Americans. African Americans, Hispanics and women continue to represent increasing proportions of persons reported with AIDS. AIDS is the leading cause of death among black men 25-44 years of age in Montgomery County.



Education is the best preventive measure against AIDS. Effective use of media and age-appropriate curricular materials are crucial in efforts to influence individual behaviors that can prevent the spread of AIDS.

SOURCES:

Health United States, Centers for Disease Control and Prevention, National Center for Health Statistics.

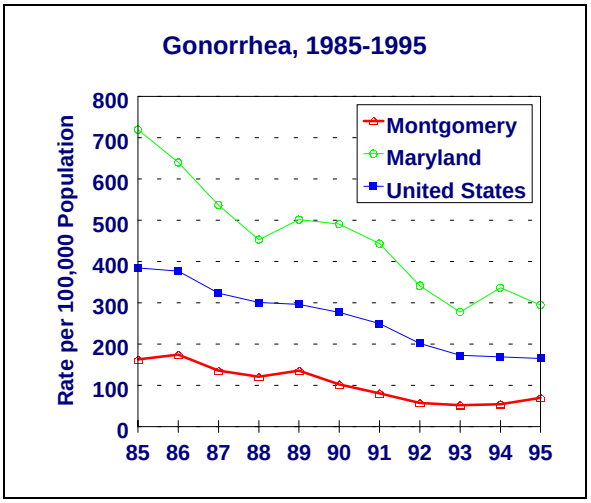
Maryland Department of Health and Mental Hygiene, AIDS Administration.

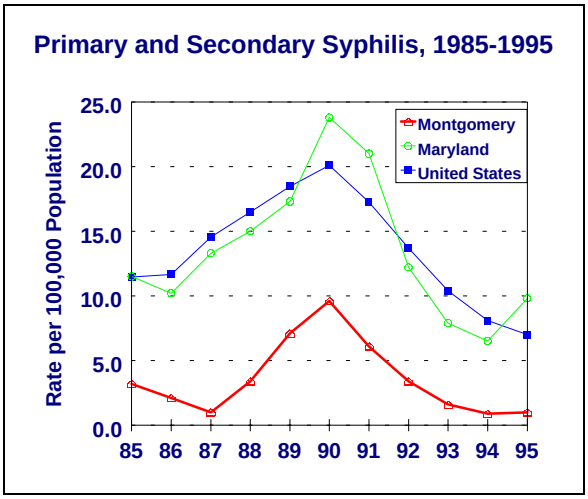
Montgomery County Department of Health and Human Services, Public Health Services, CD&E.

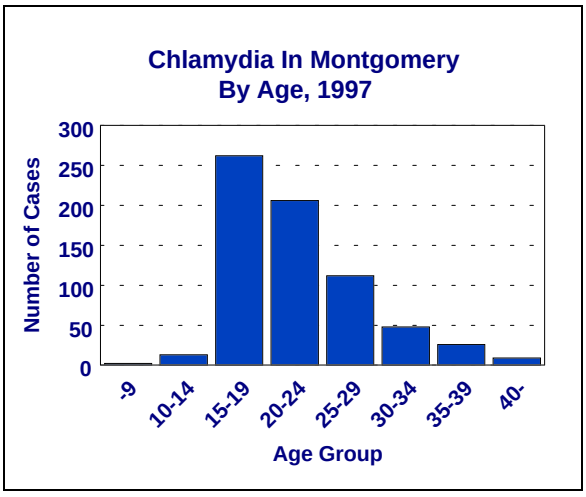
US DHHS, CDC, National Center for HIV, STD, and TB Prevention.

OUTCOME: Healthy Communities

INDICATOR: Rate Of Sexually Transmitted Diseases







WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of laboratory diagnosed cases of gonorrhea and syphilis per 100,000 population and the number of cases of chlamydia. Chlamydia is a newly reportable disease and not enough data have been collected to measure trends at this time

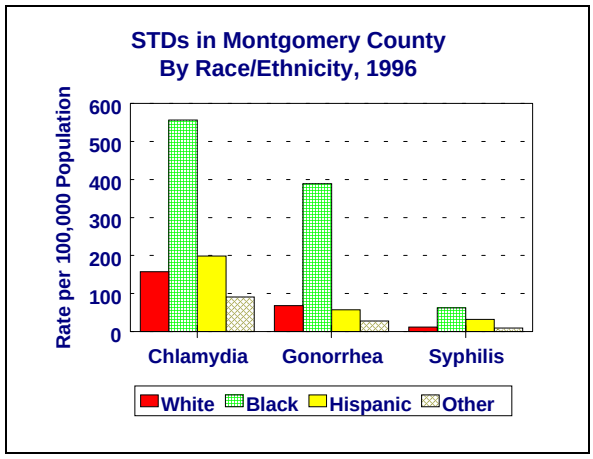
WHY IS THIS INDICATOR IMPORTANT?

Sexually transmitted diseases (STD) are infections caused by specific bacteria and viruses that pass from person to person through sexual contact. They include chlamydia, gonorrhea, hepatitis B, trichomoniasis, syphilis, genital warts, herpes, and HIV, among others. Many STDs often occur with little or no symptoms and are transmitted unknowingly. Some STDs, such as chlamydia infection, can be transmitted to newborns during delivery. Others, such as syphilis, can cause blindness, brain damage and congenital birth defects. Untreated, STDs may cause pelvic inflammatory disease and infertility in women. Chlamydia, for which Maryland began gathering statistics in 1996, is the fastest rising STD in 15 to 19 year-old females in Montgomery Country. It is one of the most common STDs in the United

States, with 4 million new cases reported each year. Acquired through unprotected sex, chlamydia infection is associated with risk for even more serious infections, such as hepatitis B and AIDS.

WHERE ARE WE NOW?

The total number of cases of gonorrhea and syphilis in Montgomery County has declined since 1990. However, cases of chlamydia seem to be on the rise. In general, STDs have been controlled through education and prevention efforts but some groups still maintain relatively high levels of infection. In Montgomery County the rate of STDs, including chlamydia, is highest among 15 to 19 year-old African-American females.



Early identification and treatment of STDs, including referral of partner(s) for diagnosis and treatment, is essential. Education focused on modifying or postponing sexual activity and directed towards minorities, adolescents and young adults is the best preventive measure for STDs.

SOURCES

Maryland Department of Health and Mental Hygiene.

Montgomery County Department of Health and Human Services.

National Center for Health Statistics. Health, United States, 1996-97 and Injury Chartbook.

World Health Organization.

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Montgomery County Department
of Health and Human Services

Key Community Outcome: SELF-SUFFICIENT

Major Outcome: CHILDREN READY FOR SCHOOL

- Indicators are being developed.

Major Outcome: CHILDREN SUCCEEDING IN SCHOOL

- Indicators are being developed.

Major Outcome: YOUNG PEOPLE MAKING SMART CHOICES

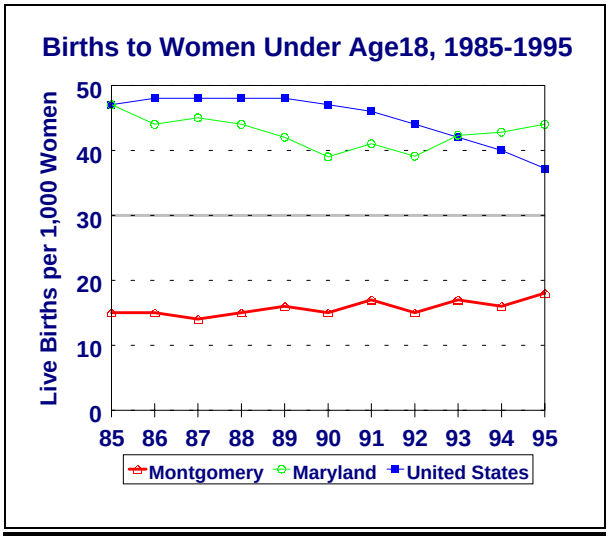
Major Outcome: ECONOMICALLY SECURE INDIVIDUALS AND FAMILIES

Major Outcome: ADULTS WITH DISABILITIES PARTICIPATING IN THE COMMUNITY

Major Outcome: OLDER ADULTS MAINTAINING INDEPENDENCE

OUTCOME: Young People Making Smart Choices

INDICATOR: Rate Of Births To Teen Mothers



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of births to Montgomery County females age 13 through 17, the target group for prevention of early childbearing, and does not include 18 and 19 year-olds, who are often out of school already and more likely to be married.

WHY IS THIS INDICATOR IMPORTANT?

The United States has the unfortunate distinction of having the highest adolescent pregnancy, abortion and birth rates in the developed world. Each year nearly one in nine women age 15 to 19 becomes pregnant in the United States. Teenage mothers are more likely to bear babies who are premature or underweight. Too-early childbearing often results in shortened educations and poverty. Teenage childbearing is also expensive. In 1990 alone, U.S. taxpayers spent about $20 billion to support families with a teenage mother. In Montgomery County, 69% of all teens, including 18 and 19-year-olds, who gave birth in 1995 (the latest year figures are available) were unmarried.

WHERE ARE WE NOW?

Montgomery County, with a rate of 18 births per 1,000 females age 13 to 18, has a lower rate than Maryland, at 44 births per 1,000 and the U.S., at 37 per 1,000. The national rate for teen births has been slowly declining since 1990 and may reach the *Healthy People 2000* (a set of nationally set health objectives that can be readily measured) goal of 30 per 1,000 females age 13 to 17 by the year 2000. Teen birth rates in Montgomery County have been stable over the past 10 years, ranging from 15 to 18 per 1,000 women, substantially below the *Healthy People 2000* goal. Teen birth rates vary greatly by race and ethnicity. County teen birth statistics for different race and ethnic groups are available for 15 to 19 year-olds, but not for those under age 18 only. Using this larger age group of 15 to 19 year-olds, the birth rate was lowest among Asians, at 26.4 per 1,000 females, followed by whites with 42.5, Hispanics with 100.3 and African Americans, 116.2.

Montgomery County has a history of effective pregnancy prevention initiatives in maintaining teen birth rates well below the state and national averages. Community-wide efforts, such as the Montgomery County Interagency Coordinating Committee on Adolescent Pregnancy Prevention and Parenting (ICCAPPP), a public and private partnership, have been working to achieve healthy outcomes. Programs that provide teens with hope for bright futures may help to reduce the racial disparities in teen pregnancy.

SOURCES:

Maryland Governor's Commission on Adolescent Pregnancy.

Montgomery County Department of Health and Human Services.

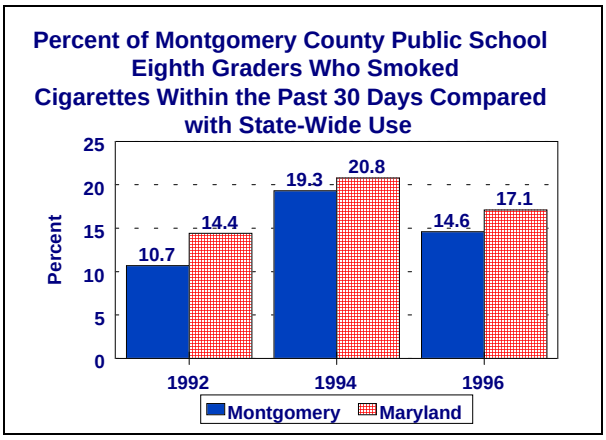
National Center for Health Statistics. Health, United States, 1996-97 and Injury Chartbook.

National Institute of Child Health and Human Development.

The Alan Guttmacher Institute, *Sex and America's Teenagers*, 1120 Connecticut Ave., N.W.,Washington, D.C., 20036.

OUTCOME: Young People Making Smart Choices

INDICATOR: Percent Of Eighth Graders Who Smoke Cigarettes



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of Montgomery County Public School eighth graders who reported in the Maryland State Department of Education's biannual survey that they had smoked cigarettes within the past 30 days. Eighth grade was chosen because, according to the survey, most young people first tried cigarettes between sixth and eighth grades.

WHY IS THIS INDICATOR IMPORTANT?

The risk of heart disease or cancer, two leading causes of death in this county, can be significantly lowered by abstaining from cigarette smoking.

WHERE ARE WE NOW?

In 1996, 14.6% of Montgomery County eighth graders reported smoking cigarettes within the past 30 days, down from 19.3% in 1994. State figures also fell, from 20.8% in 1994 to 17% in 1996. Among county sixth graders, 1.8% reported smoking cigarettes in the past 30 days, compared to 19.7% of tenth graders and 33.6% of twelfth graders. Information about how much students smoke is available statewide only. Most (37.7%) eighth graders who reported smoking in the past 30 days smoked five or fewer cigarettes daily (casual smokers). Consumption of at least one-half pack a day (regular smokers) was reported by 8.3% of eighth graders, increasing to 25.8% by twelfth grade.

Statistics about cigarette smoking by gender and race/ethnicity are available statewide for twelfth graders only. More males (55.9%) than females (44.1%) reported smoking at least one-half pack a day. Whites were much more likely to be regular smokers (32.3%) than were Asians (15.9%), Hispanics (12.1%) or African Americans (7.5%).

Although the 1996 Montgomery County and statewide figures for eighth grade smoking fell, national figures for underage smoking have been rising in recent years and smoking has proven to be difficult to reduce. The dangers of smoking tobacco are well known, and it is actually illegal for anyone under 18 to purchase, possess or use tobacco. The problem, according to one local public school official, is that most student smoking occurs off school premises and no one is actively monitoring or enforcing this law--neither the police nor the parents. A student-run monitoring program might prove effective, but

not without a real commitment to this objective by the parents themselves, many of whom still smoke. To organize efforts to discourage any smoking on school property and to help students quit smoking, Montgomery County students have formed " Students Opposing Smoking."

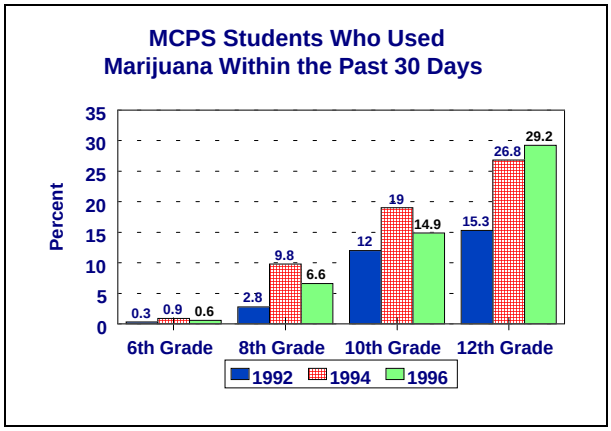
SOURCES

Maryland State Department of Education, *Maryland Adolescent Surveys (1992, 1994,1996).*

Montgomery County Public Schools, Rita Rumbaugh, Coordinator of Safe and Drug Free Schools.

OUTCOME: Young People Making Smart Choices

INDICATOR: Percent Of Eighth Graders Who Use Marijuana



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of eighth graders in public schools who reported using marijuana within the past 30 days. Marijuana use among students in other grades is included for comparison purposes. Figures are from the biannual Maryland State Department of Education's Maryland Adolescent Survey, which surveys a sample of students in sixth, eighth, tenth and twelfth grades about cigarette, alcohol and drug use. Usage among eighth graders was selected because it is hoped that early prevention will prevent marijuana use at later ages.

WHY IS THIS INDICATOR IMPORTANT?

Not only is marijuana use illegal, but it can also become addictive and result in long-term neurological impairment. Surveys show that marijuana use frequently starts in eighth grade and increases as students get older. If efforts to prevent marijuana usage among eighth graders are successful, usage among older adolescents should decline in the future. Research has shown that marijuana users frequently move on to using harder drugs--more than 90 percent of hard drug users report marijuana as their first drug.

WHERE ARE WE NOW?

Marijuana use among eighth graders increased from 2.8% in 1992 to 9.8% in 1994, and then dropped in 1996 to 6.6%. Decline in marijuana use was also reported by 6th and 10th graders. Among twelfth graders, however, marijuana use increased from 26.8% in 1994 to 29.2% in 1996.

Data for the three years from 1992 to 1996 show the increase in usage as adolescents age. In 1992 only 0.3% of sixth graders reported using marijuana within the past 30 days. Two years later, as eighth graders, 9.8% reported marijuana use in the past 30 days. Two years later, as tenth graders the percentage increased to 14.9%, increasing to 29.2% by twelfth grade. Between sixth and twelfth grade, the percentage of students who smoke marijuana increased from 0.3% to 29.2%.

Thus, it is important that the Montgomery County community slow the rapid escalation of drug use as children get older and encounter more and more drug use among their peers.

Montgomery County school officials attribute the drop in marijuana use reported in the 1996 survey to three major factors. First, the Montgomery Student Assistance Program, which provides student assistance teams for early intervention with students and their families, has been implemented in every middle school. These teams collect data on student difficulties or behaviors that may indicate drug abuse, notify the parents, express their concern and let them know what help is available. One step the family can take is to schedule an assessment to determine if there really is a problem. Second, the Montgomery County Department of Police has implemented a Community Outreach Program for alcohol and other drug abuse prevention in every middle school. Third, efforts to assure the full implementation in middle schools of the health curriculum, which includes substance abuse education, have resulted in more schools providing substance abuse education.

SOURCES

Maryland State Department of Education, *Maryland Adolescent Surveys, 1990-1996*.

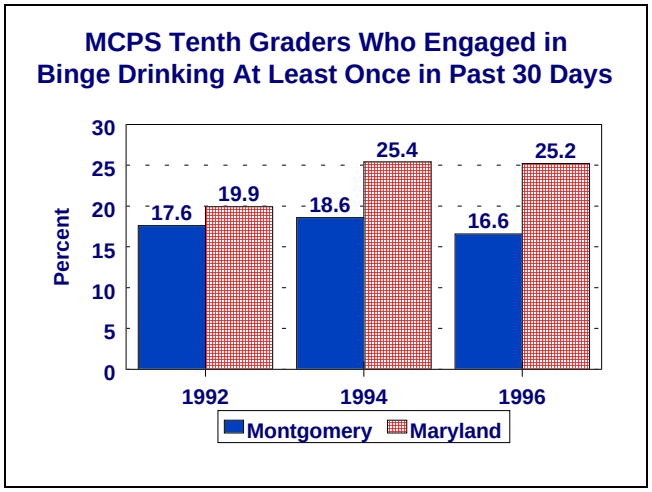
Montgomery County Drug Epidemiology Network, *Trends in Alcohol, Tobacco and Other Drug Use, 1997 (draft)*

Montgomery County Public Schools, Rita Rumbaugh, Coordinator Safe and Drug Free Schools.

Washington Post, June 27, 1997, "Marijuana's Effects on Brain Studied," A-10.

OUTCOME: Young People Making Smart Choices

INDICATOR: Percent Of Tenth Graders Who Engage In Binge Drinking



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of Montgomery County Public School tenth graders who reported in the Maryland State Department of Education's biannual survey that they had consumed five or more alcoholic drinks within the past 30 days on the same occasion, which the survey defines as binge drinking. Tenth graders were selected for this indicator because binge drinking increases greatly between eighth and tenth grades, from 7.7% to 16.6%. By senior year, 35.5% report binge drinking in the past month. Many of those who report binge drinking at least once a month often binge more frequently. Although the survey does not report the number of Montgomery County students who binged three or more times in the last month, it does report that statewide 36% of tenth graders and 40% of seniors say they engaged in this type of consumption.

WHY IS THIS INDICATOR IMPORTANT?

Binge drinking is particularly dangerous with respect to teenage driving and has serious implications with regard to potential addiction. Binge drinking also puts teens at risk for alcohol poisoning, date rape and other types of violence.

WHERE ARE WE NOW?

Binge drinking among Montgomery County tenth graders appears to have declined somewhat, from 18.6% in 1994 to 16.6% in 1996, which was much lower than the statewide rate of 25.2%. The survey provides statewide data only on drinking by gender and race/ethnicity and only for twelfth graders. Statewide, of the high school seniors who reported binge drinking, 53.1% were male and 46.9% females. Of those twelfth graders who drank beer at least three or more times in the last 30 days, white respondents had the largest percentage (46.4%) of frequent beer drinkers, followed by Asians (34.3%), Hispanics (33.7%) and African-Americans (33.1%). The pattern is different for liquor. Hispanic respondents had the largest percentage (36.0%) of frequent liquor drinkers, followed by African Americans (35.5%), whites (31.6%) and Asians (26.0%). The racial/ethnic pattern is different for the frequent binge drinkers, those who report having five or more drinks in one sitting at least three times in

the past month. Whites reported the largest percentage of frequent binge drinkers (42.4%) followed by African Americans (35.0%). There were too few Hispanic and Asian respondents to determine their rate of frequent binge drinking.

The Montgomery Student Assistance Program, which local public school officials credit with the recent declines in reported marijuana use, is targeted to eighth graders in middle schools, so is not able to have an impact on binge drinking among tenth and twelfth graders. These older, more independent teenagers are less amenable to intervention by their parents and many of them do not perceive binge drinking as a serious problem. School officials state their main focus is on reaching parents and informing them about preventing underage drinking. Drawing the Line, a public/private collaboration established in 1992 to reduce underage drinking, uses a four-pronged approach: education, enforcement, treatment and healthy activities. As a result of its efforts, the Police Department established an alcohol enforcement unit to identify and disperse underage drinking parties and issue citations to underage drinkers. Any teens receiving a citation for alcohol are referred to DHHS for treatment assessment. The Police Department also speaks at schools, including tenth grade health classes, and other community groups about alcohol issues. The Board of License Commissioners has increased its efforts to reduce underage purchases of alcoholic beverages. Drawing the Line has trained over 400 community leaders to help organize community-based prevention activities and coordinates recreational alcohol-free events for teens.

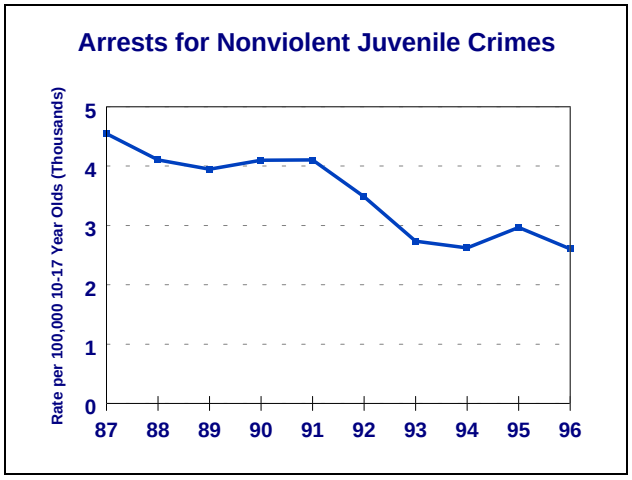
SOURCES

Maryland State Department of Education, *Maryland Adolescent Surveys (1992, 1994,1996).*

Montgomery County Public Schools, Rita Rumbaugh, Coordinator of Safe and Drug Free Schools.

OUTCOME: Young People Making Smart Choices

INDICATOR: Rate Of Juvenile Arrests For Nonviolent Crimes



WHAT DOES THIS INDICATOR MEASURE?

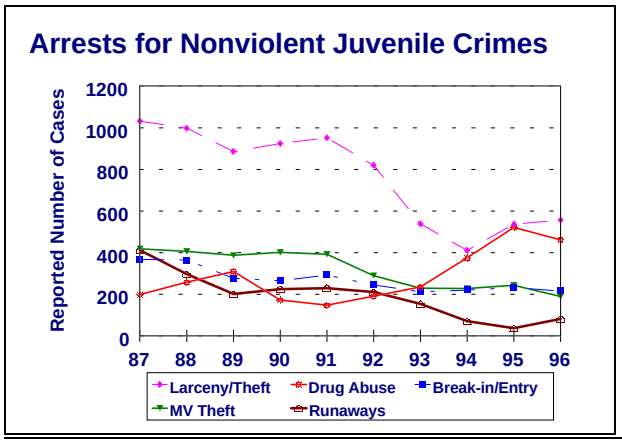
This indicator tracks the rate of arrests of Montgomery County youths under age 18 for nonviolent crimes. Nonviolent crimes are defined as all crimes except murder, rape, robbery and aggravated assault. Juvenile crime statistics are based on local police reports to the Maryland State Police, as well as reports by the Maryland-National Capitol Park and Planning Commission police, the Rockville state police barracks and the local Sheriff's Office. The arrest figures represent physical arrests. They do not include cases closed by exception, juveniles charged as adults (which became effective October 1, 1996) or juveniles charged but never physically arrested.

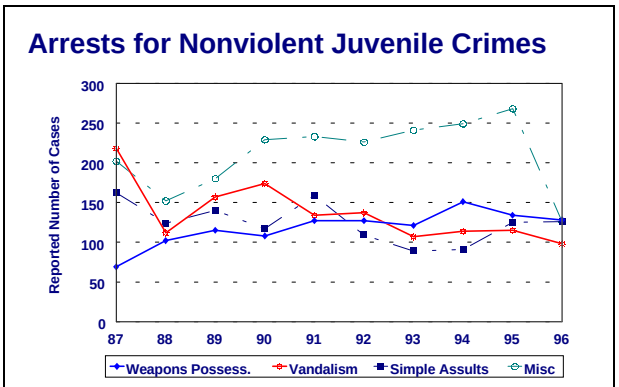
WHY IS THIS INDICATOR IMPORTANT?

These crimes are important indicators of various family and social problems, such as alcohol or drug use, school failure, physical abuse or other problems within the family.

WHERE ARE WE NOW?

Arrests for nonviolent crimes have decreased from 3,312 arrests in 1990 to 2,111 arrests in 1996. The rate per 100,000 juveniles age 10-17 has declined from 4,544 to 2,606. The most frequent causes of arrest in 1996 were larceny-theft (557), drug violations (462), and breaking or entering (216). In 1987, the most frequent causes of arrest were larceny-theft (1,032), motor vehicle theft (419), and run-aways (412). Shoplifting is included in larceny-thefts, and represents slightly more than half of all larceny-theft arrests. In the past 10 years, arrests for drugs and weapon possessions have increased, while arrests for run-aways and vandalism have decreased. Arrests for drugs and weapons have increased because of a heightened awareness about the connection between violent crime and drugs, and more aggressive strategies to combat both. Since 1993 Montgomery County Police Department has focused on ways to solve problems for run-aways and their families instead of simply making arrests. Arrests in run-away cases are made only when the youth refuses to return home.





Police and schools identified the upsurge in marijuana use early on, intensified their efforts to combat it and become involved in more joint, cooperative efforts. The schools hired special school security officers, which increased the number of juvenile offenses reported to the police, and the Youth Division of the police department increased their enforcement efforts. In addition, the Youth Division has started screening all of their cases for suspected alcohol or drug problems, referring them to the Department of Juvenile Justice for drug assessment and then diverting them into appropriate treatment programs.

Through its Operation Runaway Program, the Youth Division has succeeded in substantially reducing the number of runaways. Every runaway's parents are referred to Charter Potomac Ridge, a private treatment program, which offers free assessments for runaways, referrals to appropriate inpatient or outpatient treatment programs and free group therapy for juveniles and parents who would benefit from it.

SOURCES

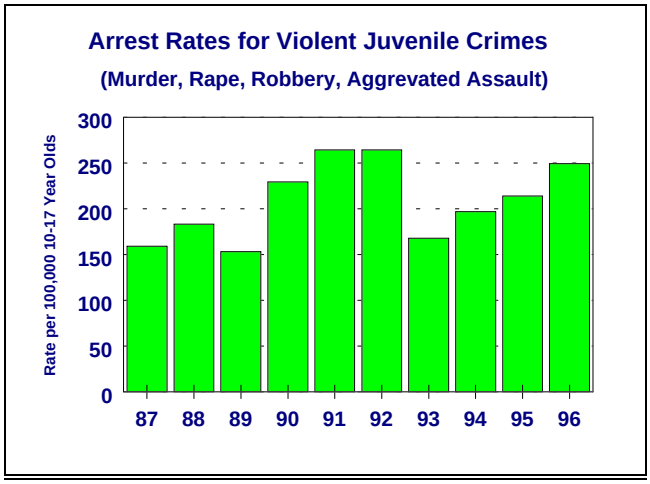
Maryland-National Capital Park and Planning Commission, Household Population by Age.

Maryland State Police, Central Records Division, Uniform Crime Report.

Montgomery Department of Police Youth Division.

OUTCOME: Young People Making Smart Choices

INDICATOR: Rate Of Juvenile Arrests For Violent Crimes



WHAT DOES THIS INDICATOR MEASURE?

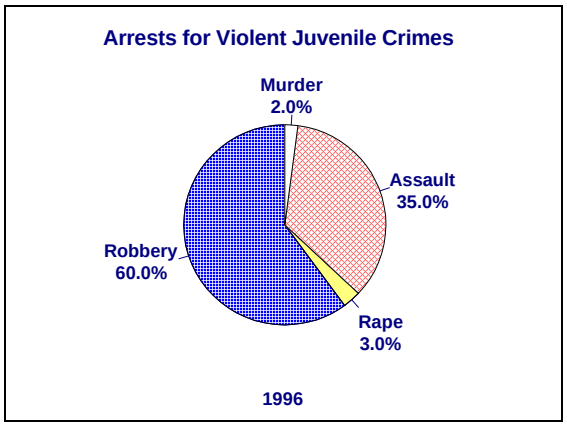
This indicator tracks the arrest rate for Montgomery County youths under age 18 for violent crimes, defined as murder, forcible rape, robbery and aggravated assault. Juvenile crime statistics are based on local police reports to the Maryland State Police, as well as reports by the M-NCPPC police, the Rockville state police barracks and the local Sheriff's Office. The arrest figures represent physical arrests. They do not include cases closed by exception, juveniles charged as adults (which became effective October 1, 1996) or juveniles charged but never physically arrested. "Robbery" includes "strong arm robbery" as well as robberies involving various weapons such as firearms, knives and baseball bats. "Aggravated assault," defined as assault with intent to maim or murder prior to 1996, is now called "first degree assault," and is defined as assaults involving firearms, risk of serious physical injury, loss of bodily function, loss of limb, or risk of death.

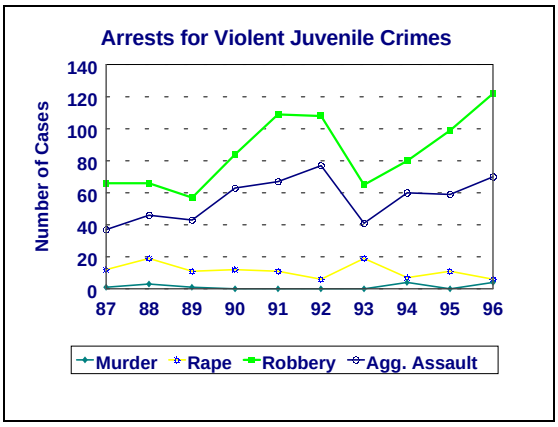
WHY IS THIS INDICATOR IMPORTANT?

Officers frequently report that teenage fights typically involve more weapons and physical violence than they used to, when disputes were frequently settled by simple fistfights. Local county police arrest data for 1996 showed that juvenile arrests for violent crimes comprised 9.4% of all juvenile arrests, compared to 5.1% in 1990.

WHERE ARE WE NOW?

The rate of violent juvenile crime has increased in Montgomery County, from 159/100,000 in 1987 to 249/100,000 in 1996, although the past nine years show yearly fluctuations. In 1996, 202 juveniles were arrested for violent crimes: 4 for murder, 6 for rape, 70 for aggravated assault and 122 for robbery.





It is apparent from looking at the actual number of juvenile arrests between 1987 and 1996 that robbery and aggravated assault figures tend to move together. The number of robberies and aggravated assaults rose sharply in the early 1990s, fell in 1993, and then rose even more sharply to set new highs three years later in 1996.

The most recent increases in robberies and aggravated assaults may be due, in part, to the Montgomery County Police Department's recent policy to press for physical arrests in juvenile felony cases.

SOURCES

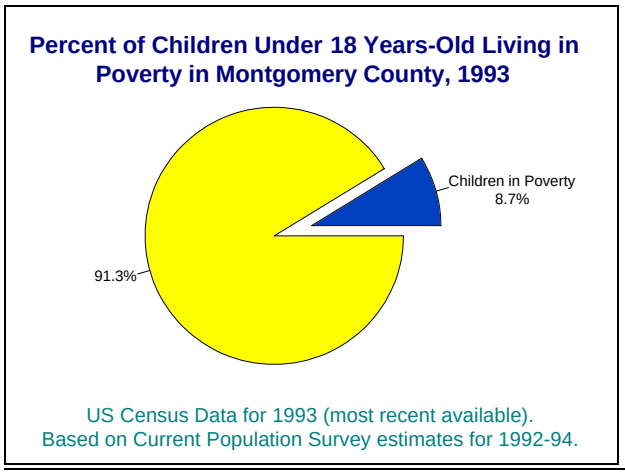
Maryland-National Capital Park and Planning Commission, Household Population by Age.

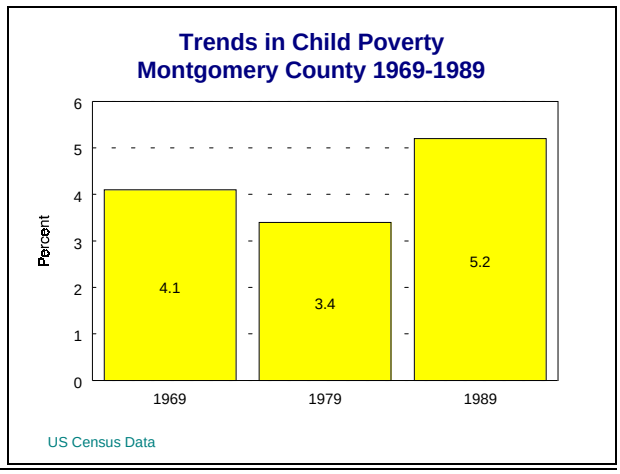
Maryland State Police, Central Records Division, Uniform Crime Report.

Montgomery Department of Police Youth Division.

OUTCOME: Economically Secure Individuals And Families

INDICATOR: Percent Of Children Living In Poverty





WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of children under 18 years-old in Montgomery County who are living below the federal poverty level. The 1993 federal poverty income guidelines for a family of four was $14,350 and for 1997 was $16,050.

WHY IS THIS INDICATOR IMPORTANT?

According to the 1990 U.S. Census, Maryland's poorest residents are children. Children living in poverty in Montgomery County are at an even greater disadvantage than those in many other Maryland counties because the cost of living is substantially higher than the federal poverty income guidelines. The minimum standard of need for a family of four in Montgomery County, defined by the Community Action Board as the minimum income needed to meet basic needs in Montgomery County, was $33,251 in 1997.

Maryland's January 1994, *Report of the Governor's Commission on School Funding*, identifies the percent of children living in poverty as the best predictor of school results. Additionally, the Annie E. Casey Foundation asserts, "Research predicts that they [children living in poverty] are at greater risk of being sick and having inadequate health care; of being parents before they complete school; of being users of easily available drugs; of being exposed to violence; and of being incarcerated before they are old enough to vote."* Poverty permeates a child's entire life and contributes to lower levels of safety and health.

WHERE ARE WE NOW?

The U.S. Census Department notes that, nationally, poverty has increased markedly between the years 1989 and 1993. In 1989, 18.3% of U.S. children under 18 years-old were living in poverty, 11.3% of Maryland children, and 5.2% of Montgomery County children. However, all rates rose in 1993. Nationally, 22.7% of children under 18 years-old were living in poverty, 15.1% of Maryland children and 8.7% of Montgomery County children.

Montgomery County children are doing better than children across both the state and the nation. However, there are more county children living in poverty now than at any time over the past 25 years.

SOURCES:

*The Annie E. Casey Foundation, *Kids Count Data Book State Profiles of Well-Being 1997*, Baltimore, 1997.

Maryland's 1996 Kids Count Factbook, Advocates for Children and Youth, Inc., 34 Market Place, Fifth Floor, Baltimore, MD, 21202, (410) 547-9200.

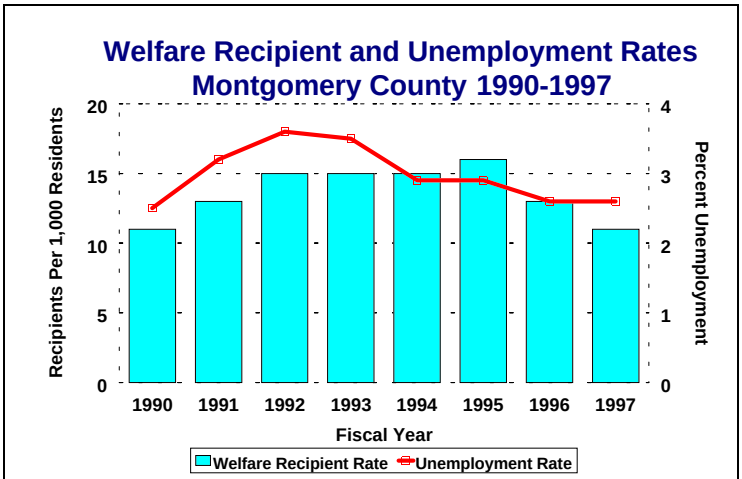
Montgomery County Community Action Board, *Report on the Minimum Standard of Need, 1997*.

United States Census Bureau, Paul Siegel, Special Assistant.

United States Department of Health and Human Services.

OUTCOME: Economically Secure Individuals And Families

INDICATOR: Welfare Rate



Source: Montgomery County Department of Health and Human Services (welfare); Maryland Department of Labor, Licensing and Regulation, Office of Labor Market Analysis and Information (unemployment)

WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the rate of adults and children receiving what was formerly Aid to Families with Dependent Children and is now called Temporary Cash Assistance. The Temporary Cash Assistance (TCA) Program is a federal-state program administered by the County, for eligible children and their parents, that provides monthly cash assistance to meet living expenses. To be eligible, children must be deprived of parental support (due, for example, to death, disability, or unemployment), but able parents must strive to become employed and seek to obtain child support from absent parents.

WHY IS THIS INDICATOR IMPORTANT?

This is a key indicator of self-sufficiency and economic well-being. The rate of residents receiving welfare is an important indicator of the economic vitality of an area and the education and skill levels of its population. A fairly recent change in the goals of the welfare system in the United States has been to move welfare recipients off public assistance by way of stable employment. The main objectives of welfare reform are to help adult welfare recipients find stable employment, help them become more self-sufficient and reduce the cost of providing public assistance. This is a difficult process, as welfare recipients are often confronted with a number of barriers to stable, lucrative employment such as lack of education; lack of job-related skills and experience; low wage, part-time, temporary or seasonal work; work shifts that make child care arrangements difficult; transportation difficulties; and lack of health insurance.

WHERE ARE WE NOW?

Montgomery County was ahead of much of the rest of the country in implementing changes to its welfare program. In 1995, before federal and state welfare reform policy changes, the Private Industry Council, a partner of the Montgomery County Department of Health and Human Services, received incentive funding for having one of the top three job retention and job placement rates in Maryland. A Welfare Reform Task Force was appointed by the County Executive in February 1996 to help Montgomery County reach a community consensus on welfare reform. The Task Force spent four months researching literature, program models and the experiences of other communities.

In April 1996, prior to federal welfare reform, the Maryland Legislature enacted state reform. The resulting Maryland Family Investment Program (FIP), which carries out this responsibility, encourages personal responsibility without jeopardizing children or other vulnerable recipients by emphasizing job search and work. It allows local communities greater flexibility in implementing and identifying locally needed programs, such as child care and transportation.

In anticipation of federal welfare reform time limits and work requirements, counties throughout the state began welfare diversion strategies in May 1996. Shortly thereafter, federal legislators passed the Personal Responsibility and Work Opportunity Act of 1996, achieving President Clinton's long-standing promise to "end welfare as we know it." The legislation eliminated the entitlement status of financial aid and imposed work requirements and time limits for recipients.

The impact of welfare reform cannot be accurately assessed unless viewed in the context of economic conditions. The accompanying graph indicates that, historically, welfare recipient rates have followed fluctuations in the economy--as reflected in the unemployment rate. In FY97, Montgomery County had an average monthly number of recipients of 8,807 or a rate of 11 recipients per 1,000 residents. This is a 31% drop from the FY95 high of 12,692 average monthly number of recipients or a rate of 16 per 1,000 residents. This drop in caseload follows the drop in the unemployment rate beginning in FY94. It is too early to determine whether the current drop in caseload is a direct result primarily of recent welfare reforms or primarily a reflection of changes in economic conditions. Clearly, the positive employment situation in Montgomery County offers a greater opportunity for the new employment-focused requirements to be successful. Additionally, it is too early to assess the long-term self-sufficiency of recipients who have left the TCA caseload. However, there is new research that can give us clues as to what is happening to recently closed cases.

"Life After Welfare," a state-wide longitudinal research project begun in October 1996, is being conducted by the University of Maryland School of Social Work in conjunction with the Maryland Department of Human Resources. The project will provide periodic reports to monitor what happens to Maryland families whose cash assistance cases are closed over the 24 months following reform. The March 1998 report, based on the first twelve months of reform, reports the following:

- At least half of those surveyed who left TCA had paid employment in the first three months after leaving TCA.
- Three-fourths of those working in months six through nine had been working steadily since their exit from cash assistance.
- Although one in five of the families returned to TCA within three months of exiting, the recidivism is lowest among those who left because they started work or because their income was above the limit.
- The majority of families leaving cash assistance are doing so voluntarily, with only 7% closing due to imposition of a full family sanction (termination of all cash benefits for non-cooperation with child support or work requirements).

- There are concerns about identifying successful strategies for working with hard-to-serve recipients --those with a long-term history of cash assistance, complex family issues or limited work history--as we move further into the five year time limitation for benefits.

SOURCES

Executive Summary: Framework For Effective Welfare Reform in Montgomery County, The Welfare Reform Task Force Report and Recommendations to the County Executive, July 1996, Rockville, Maryland.

Life After Welfare: Second Interim Report (March 1998) School of Social Work, University of Maryland for Family Investment Administration, Maryland Department of Human Resources.

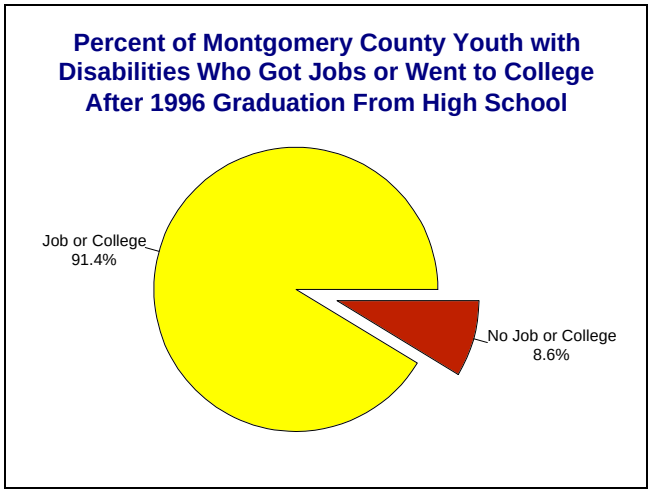
Monthly Statistical Reports, Family Investment Administration, Maryland State Department of Human Resources, FY 1989-FY 1997.

Montgomery County Department of Health and Human Services, Crisis, Income and Victim Services.

Research conducted by Schaefer Center for Public Policy, University of Maryland, Baltimore.

OUTCOME: Adults With Disabilities Participating In The Community

INDICATOR: Percent Of Youths With Disabilities Who Get Jobs Or Go On To College After High School Graduation



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of public high school students with disabilities in the highest levels of special education services (levels IV and V) who six months after graduation had a successful outcome, defined as: (1) working in a competitive employment situation; (2) working in a sheltered or adult service-supported employment situation; (3) employed and attending post-secondary education classes; (4) in college, vocational school or post-secondary education; or (5) receiving other adult services (e.g., living in a group home setting). This last category is defined in state law as a successful outcome because it represents advancement to a *higher* level of functioning than before. Disabilities among this group include autism, learning disabilities, mental retardation, other developmental disabilities, head and spinal cord injuries, chronic disease conditions, emotional impairment, orthopedic problems, and hearing and vision impairments.

WHY IS THIS INDICATOR IMPORTANT?

It has been estimated that every year 80,000 children are born in the U.S. with some type of disabling condition. As recently as 1973, Webster's *New Collegiate Dictionary* defined disability as the "inability to pursue an occupation because of physical or mental impairment." But today, with special training, many people with disabilities are able, and even expected, to work and lead productive lives. This indicator attempts to measure Montgomery County's success in preparing persons with disabilities for self-sufficient and productive lives.

WHERE ARE WE NOW?

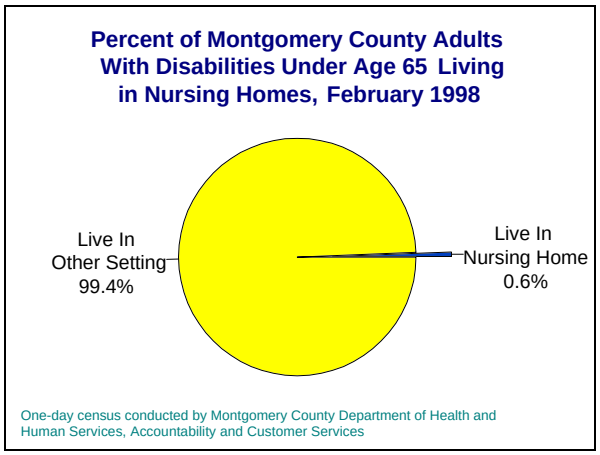
No data are available prior to the class of 1996. In January of 1997 MCPS' Transition Services Unit attempted to contact all 215 of the 1996 graduates. This included 111 who had graduated from Level IV classes and 104 who had graduated from Level V. Successful contact was made with 197 of the graduates. Of these, *91.4%* had achieved a successful outcome: 28% worked in competitive employment jobs; 22% worked in adult service supported jobs; 14% were employed and in post-secondary schools; 25% were in college or other post-secondary schools; and less than 2% were receiving adult services .

SOURCES

Transition Services Unit, Montgomery County Public Schools.

OUTCOME: Adults With Disabilities Participating In The Community

INDICATOR: Percent Of Adults With Disabilities Living In Nursing Homes



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of adults with disabilities under age 65 who live in nursing homes. The estimated number of adults with disabilities is based on the percent of Montgomery County respondents age 16-64 who stated in the 1990 U.S. Census that they had a mobility and/or self-care limitation.

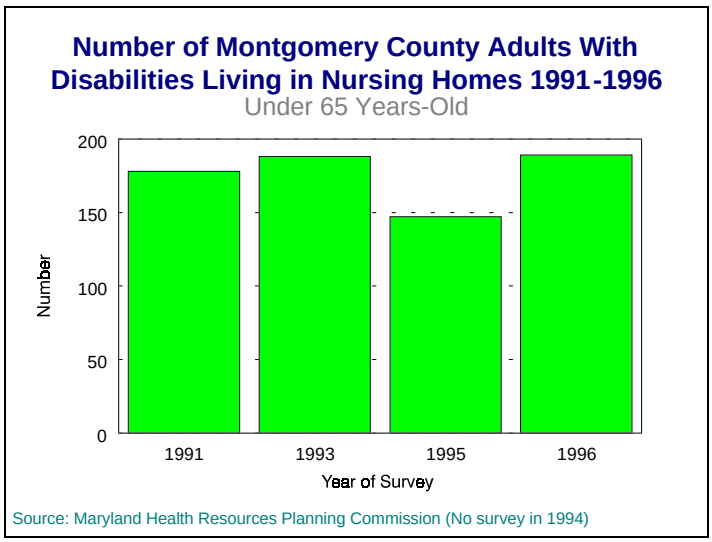
WHY IS THIS INDICATOR IMPORTANT?

Disabilities are generally characterized in three categories: developmental, injury-related, and disabilities from chronic disease and aging. Disabilities can limit one's ability to work, socialize and take care of daily needs within and outside of the home. Even with a disability, many adults still have the ability and desire to work, socialize and be self-sufficient. The goal is to decrease the rate of disabled individuals living in nursing homes and increase the number of people living in environments that provide age-appropriate socialization opportunities, as well as the ability to maintain as much self-sufficiency as possible. Living arrangements that encourage age-appropriate socialization and self-sufficiency foster higher self-esteem and a better quality of life among those that are already physically or mentally challenged.

WHERE ARE WE NOW?

Based on responses regarding mobility and self-care limitations in the 1990 U.S. Census report, 5.9% of non-institutionalized county residents are estimated to be disabled. In a one-day census taken in February 1998 by the Montgomery County Department of Health and Human Services, 189, or 0.6% of the estimated 32,559 county residents between ages 16-64 with a disability, were residing in county nursing homes. Of these, 162 were in long-term care beds and 27 in subacute skilled beds.

Earlier surveys conducted by the Maryland Health Resources Planning Commission reported 178 county residents under age 65 in nursing homes in 1991, 188 in 1993, and 147 in 1995. Preliminary results for 1996 report 190 residents. These surveys do not distinguish between those in a nursing home for long-term care and those who are there temporarily for sub-acute skilled care. These figures cannot be used to estimate the percentage of county residents with disabilities in nursing homes from 1991 to 1996 because there are no reliable estimates of the total disabled population for those years.



Although a small percentage of adults with disabilities under age 65 reside in nursing homes in Montgomery County, there is still serious debate surrounding the appropriateness of placing younger adults in nursing homes and their ability to meet younger residents' specialized needs, including socialization.

SOURCES:

Advocacy, Accessibility, Inclusion - Commission on People with Disabilities - Annual Report Montgomery County Department of Health and Human Services.

Maryland Department of Health & Mental Hygiene, Code of Maryland Regulations.

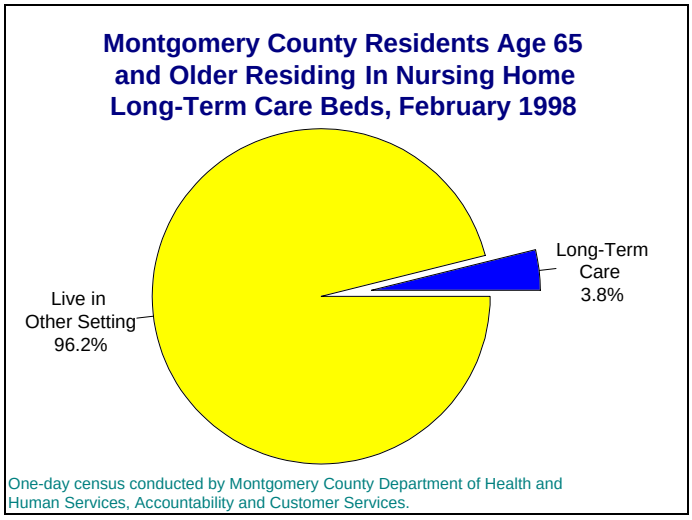
MD-National Capital Park & Planning, Montgomery County Regional Office, Publications and Information.

Montgomery County Department of Health and Human Services, Accountability and Customer Services.

Montgomery County Department of Health and Human Services, Aging and Disability Services.

OUTCOME: Older Adults Maintaining Independence

INDICATOR: Percent Of Senior Citizens Living In Nursing Homes



WHAT DOES THIS INDICATOR MEASURE?

This indicator tracks the percent of county senior citizens age 65 and older who are residing in a county nursing home for long-term services. It does not include seniors who are placed temporarily in a nursing home for recuperation.

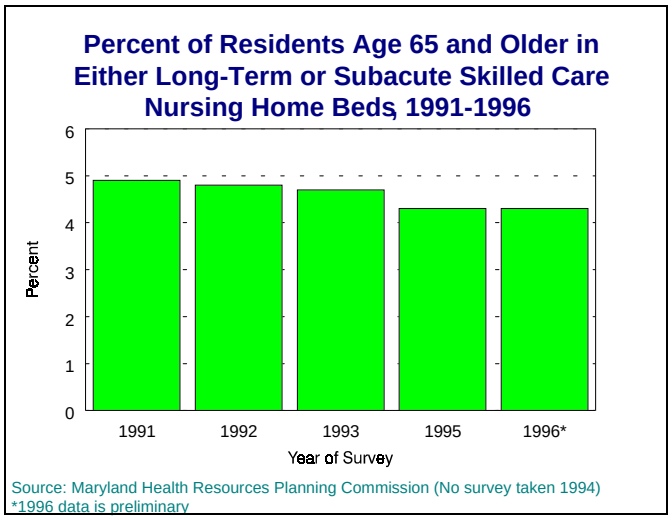
WHY IS THIS INDICATOR IMPORTANT?

When asked what they think about living permanently in a nursing home, most senior citizens say they would prefer another alternative. Most authorities in this field believe that seniors generally function better in less restrictive settings and view permanent nursing home placement as strictly a last resort. Today, many other alternatives are available for maintaining seniors in the community, such as home care, assisted living, congregate care and continuing care retirement communities. It is not clear from the data currently available whether seniors staying within the community actually live longer than those confined to nursing homes. Nevertheless, the proportion of the senior citizen population living in nursing homes is an important indicator of self-sufficiency.

WHERE ARE WE NOW?

In February 1998 the Montgomery County Department of Health and Human Services conducted a one-day census of county nursing home residents. One hundred percent of the nursing homes responded and reported 3,925 total residents. The census showed that 3.8% (3,524) of county seniors age 65 and older were receiving long-term care services in nursing homes and 0.4% (410) were receiving sub-acute skilled care.

Earlier surveys conducted by the Maryland Health Resources Planning Commission (MHRPC) show a gradual decrease in the percentage of Montgomery County residents living in nursing homes for all types of care. While the MHRPC surveys do not distinguish between those in a nursing home for long-term care and those residing there temporarily for sub-acute skilled care, as did the DHHS survey, they are helpful in tracking trends in nursing home use generally. These figures for all seniors living in nursing homes declined from almost 5% to a little over 4% between 1991 and 1996.



SOURCES:

Maryland Health Resources Planning Commission.

Maryland-National Capital Park and Planning Commission.

Montgomery County Department of Health and Human Services, Accountability and Customer Services.

Montgomery County Department
of Health and Human Services

Measuring Progress

Department Program Goals and Measures

"Program measures tell us the effectiveness of the program for those that it serves"

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAM MEASURES

Although listed under the categories of safe, healthy and self-sufficient, programs can contribute to more than one outcome

HHS PROGRAM AND GOAL	PROGRAM MEASURES
SAFE	
Abused and Neglected Children Protect children from abuse and neglect Achieve long term stability for children who are abused or neglected	• Percent of families whose abuse and/or neglect cases are reopened within one year of receiving protective services • Length of stay for children in temporary out-of-home placements
Partner Abuse Increase the safety of victims of domestic violence	• Percent of victims of domestic violence who establish *safer living conditions* after leaving the family residential shelter • Percent of abusers court referred for treatment who complete treatment • Percent of court referred abusers who report ceasing abuse following treatment
Adult Protection Protect frail elders and adults with disabilities from abuse and neglect	• Percent of frail elderly and adults with disabilities who are reported to be repeat victims of abuse, neglect, self-neglect or financial exploitation within six months of a first report
Assisted Living Protect frail elders and adults with disabilities from abuse and neglect	• Percent of adults at high risk for neglect, abuse, or exploitation, made safer by placement in foster care or group homes • Percent of adults residing in foster care or group homes six and twelve months after placement
HEALTHY	
Foodborne Diseases and Illnesses Protect the public from foodborne illness	• Rate of reported foodborne diseases per 100,000 population in Montgomery County
Tuberculosis Control Prevent the spread of tuberculosis	• Percent of active TB patients placed on Directly Observed Therapy
Adult Addiction Services Reduce harm to individuals, families, and the community from substance abuse disorders Increase an individual's and family's ability to be self-sufficient	• Percent of clients successfully discharged from treatment • Percent of clients referred from the criminal justice system
SELF-SUFFICIENT	
Vocational Skills Development Increase self-sufficiency by improving educational and vocational skills	• Percent of corps members leaving the program who attained a GED or high School diploma • Percent of corps members leaving the program who entered the job corps, returned to school, or got a job
Child Care Subsidies Support economic self-sufficiency among low- and moderate-income families	• Average amount of child support received by families receiving child care subsidies
Teen Parent Support Reduce teen pregnancy Ensure the health of babies born to teen parents Promote economic security for teen parents and their babies	• Percent of pregnant teens in high school receiving prenatal care in the first trimester • Percent of all infants born to high school teens that are of low birth weight (5.5 pounds or 2,500 grams) • Percent of repeat pregnancies among high school teen participants within 12 months • Percent of pregnant or parenting teens among program participants who complete the current school year, graduate or receive a GED • Percent of infants born to high school students for whom legal paternity has been established
Services For Homeless Help homeless adults become self-sufficient	• Percent of homeless, single adults sheltered • Percent of homeless, single adults placed in transitional housing • Percent of homeless, substance abusing individuals who engage in treatment
Adult Mental Health Increase stability for people with mental illness	• Percent of adult mental health clients hospitalized in psychiatric facilities
Welfare Reform Increase employment for both those seeking and receiving welfare benefits Decrease cost per recipient	• Percent of Temporary Cash Assistance *applicants* who become employed before payment of benefits begins • Percent of Temporary Cash Assistance *recipients* who become employed • Average monthly benefit cost per Temporary Cash Assistance recipient household

OUTCOME: Safe Individuals and Families

GOALS: *Protect children from abuse and neglect. Achieve long term stability for children who are abused or neglected.*

ABUSED AND NEGLECTED CHILDREN

Mandated by law to respond to reports of child abuse and neglect, DHHS provides prevention, protective and remedial services for children referred and for their families, foster parents and adoptive parents. Services include child protective services, child foster care, adoption, in-home aide services and intensive short-term family preservation services to families with children at risk of removal from the home due to neglect or abuse.

PROGRAM MEASURES

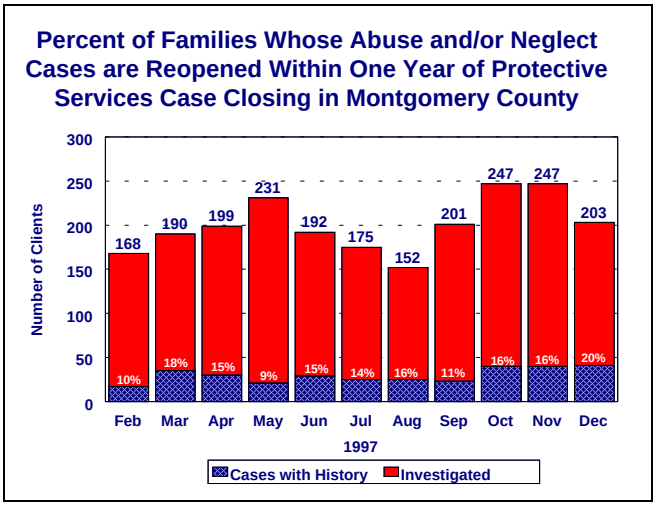
1. Percent of families whose abuse and/or neglect cases are reopened within one year of receiving protective services.
2. Length of stay for children in temporary out-of-home placements.

TREND ANALYSIS

Reported cases of child maltreatment have been increasing nationally, and in Montgomery County the incidence of abuse and neglect increased 30% in FY97. Children are entering out-of-home care at a younger age and with more serious problems, resulting from physical, sexual or emotional abuse, alcohol or drug exposure, poverty and homelessness.

In 1997, there were several highly publicized child abuse cases, not only in Montgomery County but also in the surrounding jurisdictions, which resulted in a 44% increase in referrals to protective services in Montgomery County. To assure that DHHS is effectively meeting its child protection responsibilities, Montgomery County initiated an intensive review of local procedures and services.

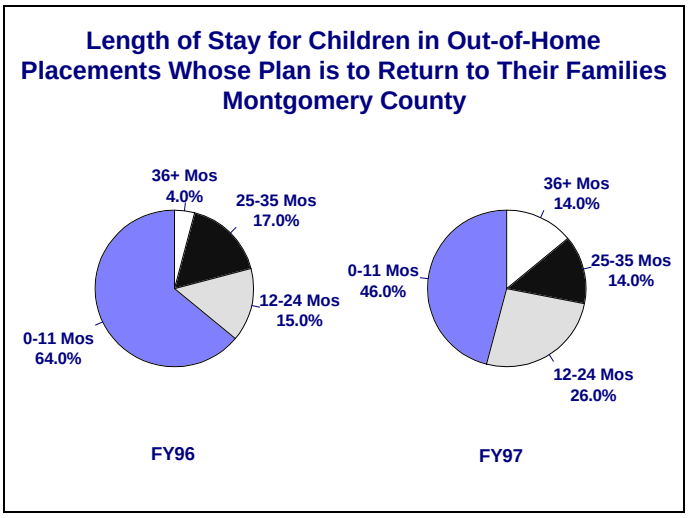
Program Measure 1. Percent of families whose abuse and/or neglect cases are reopened within one year of receiving protective services.



Note: The data for Program Measure 1 were not collected prior to February 1997. The department will be refining the graph to reflect cases of *confirmed* abuse. The current graph reflects cases *reopened* for *investigation*.

This measure monitors the percent of child abuse and neglect cases in Montgomery County which were reopened for *investigation* within one year of the case closing. DHHS has refined its data collection techniques so, from now on, it can track cases where the abuse or neglect is *confirmed* in reopened cases. DHHS will monitor this measure quarterly to determine whether children leaving the system remain safe. Success in this measure reflects whether services were effective and whether adequate family and community supports are in place to ensure the child's safety.

Program Measure 2. Length of stay for children in temporary out-of-home placements.



Note: The data for Program Measure 2 do not include children who are in an adoption, long-term foster care or independent living plan. It is based on cases open at the end of the fiscal year.

Local data for this measure are available only for 1996 and 1997. The graph shows that in Montgomery County, the percentage of children who have been in out-of-home placement for more than two years has increased from 21% to 28% between 1996 and 1997, with those in placement for more than three years increasing from 4% to 14%. Success in this measure is to reduce the length of stay in out-of-home placement without compromising the health and safety of the child, thus contributing to stability for the child. Successfully improving this measure is also partially dependent upon court decisions and legislative action regarding parental rights.

WHAT WORKS

To protect children from abuse and neglect and to achieve long-term stability for children who are abused and neglected requires: 1) a broad view of the problem, 2) family preservation services, 3) permanency planning and support services, 4) assessing the well-being of the child.

A Broad View of the Problem

Recent research views the issue broadly in terms of strengths and weaknesses in both the family and the community. Risk factors, such as substance abuse, domestic violence, mental health problems, homelessness and poverty, are strongly associated with abuse and neglect. Strategies which address these underlying concerns tend to be effective. Child protection requires addressing broader community issues such as community violence, substance abuse, failing neighborhoods and joblessness.

Keeping children safe is more likely to occur when it becomes the priority for the whole community. Strengths, such as a strong connection to family and other caring adults, and strong connections to community, can serve as protective factors for children. For example, a successful program in Cuyahoga County, Ohio, is building its system around the concept of neighborhood-based foster care. As a result, foster family recruitment has increased 45% and adoptive placements by 200%, while the number of children placed in institutions has been cut in half.

Family Preservation Services

The characteristics that most strongly predict failure in family reunification are a history of failed drug rehabilitation, previous involvement of child protective services, or previous removal of a child because of substance abuse. Family preservation programs attempt to eliminate the underlying causes of family dysfunction. Essential services to support family preservation include mental health counseling, addiction services, parenting classes, and concrete services, such as housing and medical care. One state that has experienced success with family preservation programs is Kansas. The effectiveness of this strategy is seen in the low rates of child abuse and neglect incidents and the number of children removed from the home during program participation and within six months of case closure.

In the Montgomery County " Families Now" family preservation model, which provides for intensive, time limited (3 to 9 months) services, caseworkers carry small caseloads and assist families to resolve a variety of difficulties. The pairing of parent aides with social workers is a key component of the service. During FY97 this program served 250 children: only 19 (7.6%) required placement in foster care following the provision of services. A newly formed unit that focuses on family reunification served 214 children: 64 (30%) were reunited with their families within nine months of placement or a decision was made to change the plan to adoption. Results are not as successful for those families who require longer term services, frequently with court involvement.

Permanency Planning and Support Services

When children clearly will not be able to return to their families, adoption is often a goal. Support services, such as counseling and respite care, are often needed to provide the support that many families need after adopting a child with special needs. As a result of system changes in Montgomery County, adoptions were finalized for almost 50 children per year in FY96 and FY97, a 66% increase from about 30 per year in FY94 and FY95.

Assessing the Well-being of Children

In the past, success in working with families was measured by parental compliance with treatment plans and visitation schedules. The measure of success was not child-focused. What is missing in the literature and practice is any clear method to evaluate the impact of services on the child's well-being. Until this is addressed, it is not possible to evaluate whether services are truly protecting children.

STRATEGIES

To protect children from abuse and neglect and to achieve long-term stability for children served by the program, Child Welfare Services will focus on the following strategies:

Case Assessment

- Ensure that staffing is adequate to meet the demand for investigation.
- Implement model protocols for child protection services, including screening, intake, assessment and intervention.
- Strengthen communication and reporting procedures with Montgomery County Public Schools.
- Expand the Sexual Abuse Treatment Center at Shady Grove Adventist Hospital to serve victims of physical abuse and neglect.

Treatment Intervention Strategies

- Provide a mechanism to follow up on cases where abuse/neglect is confirmed but which are closed because they do not meet the state criteria for mandatory continuing services.
- Ensure early intervention with high- and imminent-risk families, including new mothers and infants at high risk for neglect and out-of-home placement.
- Pilot a substance abuse and mental health prevention model with Head Start families.
- Develop a structured response system for families with substance abuse problems.
- Initiate a prevention educational campaign for Shaken Baby Syndrome.

Integrated, Community-Based Services

- Provide child welfare services in decentralized locations and integrated with other services.
- Develop strong, community-based mentoring programs.
- Develop neighborhood-based foster and adoptive family recruitment and placement.
- Develop natural community-based supports for families at-risk.
- Create Children Outreach Teams to provide a continuum of services for children and youths exhibiting violent or disruptive behavior, delayed emotional development or who are clinically neglected.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Welfare Services**

OTHER HHS PROGRAMS
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Care** • **Infants and Toddlers Program** • **Linkages to Learning** • **Child and Adolescent Mental Health Services** • **School Health Services**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES • **Outpatient Addiction Treatment** • **Addiction Services Coordination** • **Adult Outpatient Mental Health Services**
CRISIS, INCOME, AND VICTIM SERVICES • **24-Hour Crisis Center** • **Community Outreach** • **Prevention and Crisis Intervention** • **Public Assistance Benefits Certification** • **Rental Assistance** • **Shelter Services** • **Partner Abuse Services** • **Transitional Housing and Services** • **Victim Assistance and Sexual Assault Services**
PUBLIC HEALTH SERVICES • **Community Health Nursing** • **Specialty Medical Evaluations**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Office of the County Attorney	**Maryland State Department of Human Resources**	**Reginald Lourie Center**
Montgomery County Police Department	**District Court of Maryland, Juvenile Division**	**Shady Grove Adventist Hospital/ Sexual Abuse Center**
Montgomery County Public Schools	**Department of Juvenile Justice**	**Adult Addiction Services**
Housing Opportunities Commission	**Office of the State's Attorney**	**Community Ministry of Montgomery County/ Friends in Action Program**
	Circuit Court of Maryland	**Court Appointed Special Advocate Program (CASA)**
		Collaboration Council
		Mental Health Association
		CPC Health

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OUTCOME: Safe Individuals and Families

GOAL: Increase the safety of victims of domestic violence.

PARTNER ABUSE

Services, including residential, supportive, educational, advocacy and counseling services, are provided for victims of domestic abuse. Counseling services are also provided to abusers.

PROGRAM MEASURES

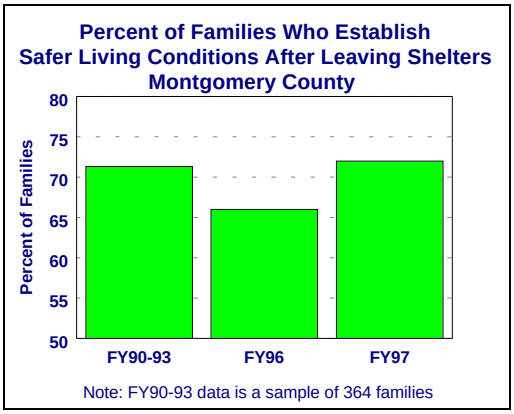
1. Percent of victims of domestic violence who establish *safer living conditions* after leaving the family residential shelter.
2. Percent of abusers court referred for treatment who complete treatment.
3. Percent of court referred abusers who report ceasing abuse following treatment.

TREND ANALYSIS

Montgomery County reports of domestic violence incidents rose from 909 in 1987 to 2,107 in 1995, doubling in eight years. This increase is largely due to improved state mandatory reporting laws and increased awareness that victims have alternatives. Media attention from the O.J. Simpson trial also contributed to an increase in reports of domestic violence in 1995 and 1996. Still, with an estimated 35% to 50% of women experiencing domestic violence sometime in their lives, many more incidents remain unreported due to the social stigma. In October 1995, Montgomery County adopted a coordinated systems response to domestic violence: *Montgomery County Against Domestic Abuse.*

Montgomery County has always had a strong commitment to the safety of victims and their children: no women with children are ever refused shelter. The current shelter facility has served approximately 200 families each year since 1979. When the shelter residence is at capacity, women and children fleeing violence are sheltered in a local motel. While providing shelter in a motel meets the immediate goal of safety, addressing the underlying issues of domestic violence may be interrupted if women return home before they receive the case management and educational services available in the family residential shelter.

Program Measure 1. Percent of victims of domestic violence who established *safer living conditions* after leaving the family residential shelter.



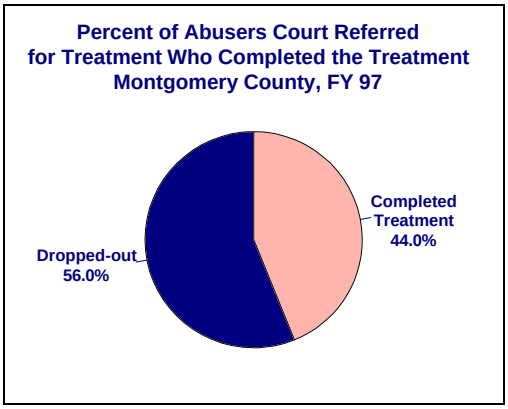
Note: Determination of whether *safer living conditions* have been established is based on staff surveys of clients' discharge status.

- From 1990 to 1993, an average of 71% of clients established *safer living conditions* upon leaving the shelter.
- In FY96, the percentage declined to 66%, reflecting the decrease in the availability of low-income housing due to the Housing Opportunities Commission's waiting list being closed to new applications and a limit placed on the number of applications accepted by the state Rental Assistance Program.
- In FY97, 72% of sheltered families found safer living conditions.

The recent trend is for clients to choose returning home with legal protection rather than seeking independent living. This may be due to lack of available low-cost housing as well as protection orders becoming a more viable option. Since October 1997, victims who are married or who have lived with the abuser for 90 days out of the past year can obtain a Civil Order of Protection from Domestic Violence, which allows them to return home *with protection* while the abusive mate is required to vacate the home for a period of up to one year.

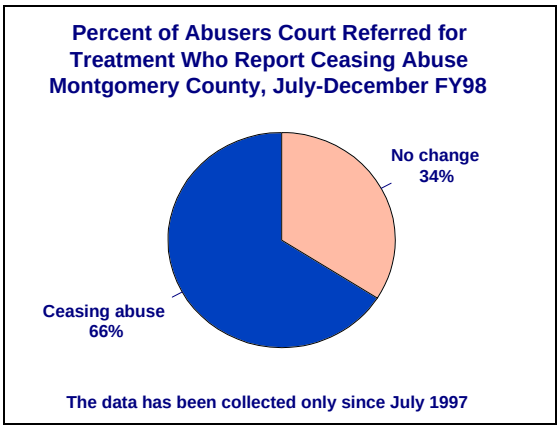
Those domestic abuse victims requiring longer stays at the family residential shelter are those who don't have a home to return to under protection. Family residential shelter is often sought by foreign-born women who have no extended families to care for them and who represent more traditional male-dominated cultures where "taking legal action" to protect oneself is not culturally acceptable. These women are often the least prepared to support themselves, may demonstrate considerable difficulty keeping free of abusive relationships and require substantial intervention over a longer period of time to develop attitudes and skills to enable them to choose safe lifestyles.

Program Measure 2. Percent of abusers court referred for treatment who completed treatment.



In FY97, 56% of abusers referred to the Abuser Intervention Project for treatment dropped out. Studies point to a lower recidivism rate in physical abuse for those who complete programs than for those who do not complete typical domestic violence offender treatment. What studies have not yet clarified is how much of the improvement is due to criminal justice sanctions, divorce or separation by the partner, or lack of other problems, such as substance abuse, and how much is due to the treatment provided.

Program Measure 3. Percent of court referred abusers who report ceasing abuse following treatment.



To prevent future domestic violence, the Abuser Intervention Project provides individual and group counseling services to abusers who are either referred by the court or self-referred. Decreases in abusive behavior are measured through pre-and-post treatment questionnaires completed by clients. Although offender self-reports are a better measure of recidivism in partner abuse than in criminal justice cases, they are not as good as partner/victim reports. In FY98, 66% of clients completing abuser intervention counseling reported no abusive behavior at the end of treatment. Currently, data are not available on the reports of partners regarding decrease in abusive behaviors. DHHS will conduct a survey of partners in FY98 to ascertain whether abusive behaviors decreased following treatment. At this time it is not possible to track new incidents of abuse through police or court involvement.

WHAT WORKS

Services for victims of domestic violence can be categorized as: 1) shelters for battered women; 2) peer support groups; 3) advocacy; and 4) abuser treatment programs. Research on the effectiveness of shelters indicates that for some women, shelters appear to limit repeat episodes of violence, and states with higher numbers of shelters have fewer spousal murders. The women who go to shelters do not represent all types of domestic violence victims; shelter residents tend to have lower incomes than those victims with higher incomes who have the means to obtain alternative forms of shelter when fleeing domestic violence. Experience has shown that transitional housing programs, which provide longer periods of residence with support services, help women to become economically independent from the batterer.

Montgomery County shelter staff perform advocacy services by teaching victims of domestic violence about their options and about available community resources. Evaluations of advocacy services show that while they may not reduce the risk of future violence, they do improve the victim's self-esteem, feelings of empowerment, and social supports.

Many courts, including Montgomery County, refer batterers for treatment; however, enforcement of treatment completion is lax, both locally and nationwide. About 33 to 50 percent drop out of treatment nationwide, and 56 percent in Montgomery County. There is scant evidence about which abuse treatment models are most effective. This is further complicated by the fact that batterers comprise a variety of subpopulations with different associated problems. Also, little is known about whether treatment or punitive sanctions are more effective with each subpopulation. Since research has shown a decrease in repeat incidents of domestic violence among batterers who complete treatment, it is important that there are sanctions for dropping out of treatment and that specialized treatment programs for various subgroups of batters are developed.

Collaborative strategies that bring together caseworkers, police, prosecutors and judges appear promising. Evaluations of batterer treatment programs, protective orders, and arrest policies suggest that the impact of each of these interventions may be enhanced if they are part of a broad- based strategy. A 1996 study reported that a coordinated community response resulted in about half of the abusers successfully abstaining from reabuse in a two-year period.

Studies conducted by the Office of Alcohol and Drug Abuse Programs show that 50% of all spousal assaults involve alcohol. Therefore, the integration of treatment for substance use disorders is a critical part of successful interventions to address domestic violence.

STRATEGIES

To increase the safety of victims of domestic violence, DHHS will:

- Enhance the coordinated systems approach to domestic violence by participating in the Task Force on Domestic Violence. The purpose of the task force is to facilitate cooperation and communication among all agencies involved in responding to domestic violence and promote legislative proposals that will enhance victim safety.

- Work with the criminal justice system to encourage a stronger response to noncompliant behavior for those abusers who continue to repeat abusive behavior after completing treatment.

- Build a new eighteen-bedroom Center Against Domestic Violence to open in early 1999. This will double the current shelter capacity and eliminate the need for motel placements. Residents may stay at the center for up to 60 days to recover from abusive daily living relationships and to arrange for *safe living* accommodations.

- Monitor whether the additional shelter beds (so that all women who seek shelter receive the full range of shelter educational and advocacy services) results in a larger percentage of women establishing safer living conditions when they leave the shelter.

- Continue support groups for battered women.

- Regularly review the literature to identify the most effective treatment models for different subgroups of batterers.

- Continue outreach to the Hispanic community.

- Conduct a survey of partner/victims in FY98 to ascertain whether the abusive behavior has decreased following Abuser Intervention Project treatment services.

- Provide education to community partners on partner abuse issues related to substance abuse.

- Monitor the results of the expanded 26 week Abuser Intervention Project treatment program.

- Improve integration of substance abuse treatment services into domestic violence interventions.

- Provide support to Montgomery County Community Partnership to provide community education on partner abuse.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
CRISIS, INCOME AND VICTIM SERVICES • **Partner Abuse Services**

OTHER HHS PROGRAMS
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE • **Adult Outpatient Mental Health Services** • **Outpatient Addiction Treatment** • **Addiction Services Coordination**
CRISIS, INCOME AND VICTIM, SERVICES • **24-Hour Crisis Center**
PUBLIC HEALTH SERVICES • **Health Promotion and Prevention** • **STD/HIV Prevention and Treatment**
CHILDREN, YOUTH AND FAMILY SERVICES • **Child Welfare Services**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Police	**Department of Human Resources** • **Transitional Programs**	**Maryland Network Against Domestic Violence**
Sheriff	**Governor's Office on Crime Control & Prevention** • **Violence Against Women's Act Grants Coordination**	**Mental Health Association of Montgomery County: Voices *vs.* Violence**
State's Attorney	**Family Violence Council**	**Montgomery County Community Partnership**
Corrections and Rehabilitation		**DHHS Victim Advisory Board**
Circuit Court		**County Executive** **Task Force Against Domestic Violence**

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OUTCOME: Safe Individuals and Families

GOAL: Protect frail elders and adults with disabilities from abuse and neglect.

ADULT PROTECTION

DHHS protects vulnerable adults with disabilities and frail elderly individuals from abuse, neglect, self-neglect and financial exploitation. Adult Protective Services (APS) staff investigate complaints, ensure that clients have a sheltered environment, follow up as case managers, and provide community and professional education. Services are provided in coordination with the Crisis Center, the Montgomery County Police Department, the Office of the County Attorney, and a number of other community resources.

PROGRAM MEASURE

1. Percent of frail elderly and adults with disabilities who are reported to be repeat victims of abuse, neglect, self-neglect or financial exploitation within six months of a first report.

TREND ANALYSIS

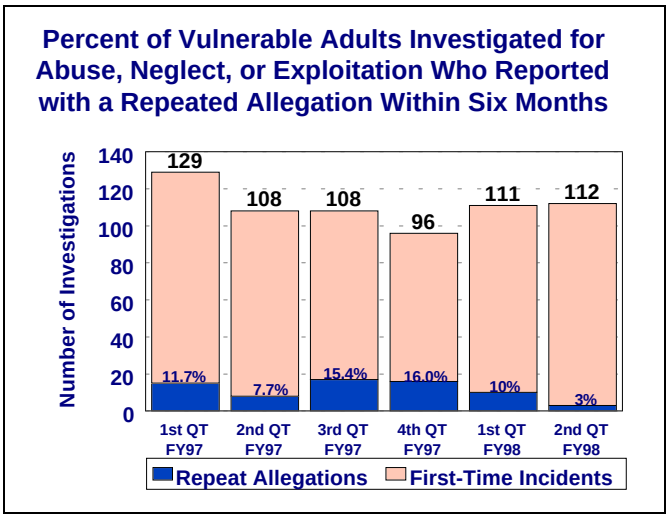
Maryland legislation has established a reporting system to protect vulnerable seniors and adults with disabilities from abuse, neglect and exploitation. In Montgomery County, the vast majority of Adult Protective Service referrals and investigations are for seniors. Between FY96 and FY97 there was an 18% increase in investigations for seniors. Of the four APS criteria--abuse, exploitation, neglect and self-neglect--self-neglect is most frequently reported in Montgomery County (77%). Self-neglect usually occurs in older, mentally disabled persons living alone who are no longer capable of independent living. Persons over age 85 are the most at risk.

The American Medical Association estimates that only one in 14 cases of elder abuse in the United States is reported. National estimates of the annual number of elderly who have been abused or neglected range from 2.6% to 25%. Victims of elder abuse tend to be women over age 75, with at least one physical or mental impairment, widowed and without sufficient income to live independently. Adult children are the most frequent abusers of the elderly, followed by spouses and other family members.

There is little research on the causes of elder self-neglect. There is no clear cause of self-neglect, though some possible factors have been identified: organic brain impairment, mental illness, alcohol use, misuse of medications (or over-medication), fear of seeking help, fear of becoming a burden to others, fear of losing independence and/or privacy, depression, lack of awareness of available services, inability to admit limitations, inaccessibility of formal support systems, lack of family support systems, and, finally, family conflicts.

There is little information nationally on the abuse or neglect of adults with disabilities who are not seniors. As in the case of seniors, most cases referred to APS are for self-neglect.

Program Measure 1. Percent of frail elders and adults with disabilities who are reported to be repeat victims of abuse, neglect, self-neglect or financial exploitation within six months of a first report.



Note: The number that appears above each bar is the total number of investigations for that quarter.

Data on repeat reports are available only for FY97 through the first two quarters of FY98. In the first two quarters of FY98, there were 223 total reports, compared to 237 reports the first two quarters of the previous year. Repeat reports for the first two quarters of FY98 were 6.2%, down from 10.7% for the first two quarters of FY97.

In FY97 there were a total of 441 adult protective service investigations. The recidivism rate, defined as the percent of cases with repeat allegations within six months, ranged from a high of 16% to a low of 7.7% Success in this measure indicates that the interventions were effective and that community support systems were in place to deter further abuse, neglect self-neglect or exploitation.

WHAT WORKS

The following factors, either alone or in combination, are thought to contribute to the act of abuse: unresolved family conflict; long-standing patterns of violence in the family; vulnerability and dependency of the older person; mental illness, alcoholism or drug abuse in the older person or caregiver; stress of providing care to the older person; financial dependency of the caregiver on the older person; social isolation; and inadequate housing.

Without intervention, elder abuse will often reoccur. Researchers have found that in 58% to 70% of reported cases, the pattern of abuse was repetitive. This phenomenon is not surprising since the conditions which precipitate abuse and neglect are chronic and ongoing. Prior to a report of abuse, caregivers have, on the average, been providing care for the older person for 9.5 years. The American Association of Retired Persons (AARP) reports that middle class families suffer the greatest stress and fatigue in caregiving. Unlike affluent families, middle-income families cannot afford outside help and unlike lower-income families, they do not display intergenerational dependence. Most families do not anticipate the commitment of time and money that caring for a frail relative entails. By the time this becomes apparent, the family is often so stressed that they cannot accurately assess their situation or make changes without outside intervention.

Appropriate interventions in cases of elder abuse are unique to each family situation. Interventions include mental health counseling and caregiver support, adult day care, assisting the family to address the health care needs of the elderly person, and placement in a long-term care residential setting or nursing facility.

Successful strategies for preventing further abuse or neglect include: *counseling, training, personal assistance, respite for caregivers and crisis intervention*. Prevention planning requires educating adults with disabilities, seniors and particularly caregivers about the need to make plans in advance for providing care. Although up to 80% of all personal health care for the elderly is provided by family members, few people anticipate the frustration, fatigue or cost of providing this care. A community education effort which provides information to seniors and families on planning for incapacitation is one successful strategy for preventing adult abuse or neglect. Families providing care for disabled family members also need more community support and recognition of their effort. Public awareness programs which both educate the community about the concerns of caregivers and provide caregivers with information about the availability of respite, adult day care services and other community support systems are a first step in preventing and reducing recidivism.

There is little information on successful strategies to prevent or treat elder self-neglect. Rathbone-McCuan and Fabian recommend focusing interventions on specific problems--such as psychiatric treatment for depression, substance abuse treatment specifically designed for elders, improving accessibility to formal support systems such as in-home aide services, and, finally, shifting the focus of treatment from individual to family problems.

Peer counseling has been demonstrated to be an effective method of extending the reach of mental health professionals to seniors.

STRATEGIES

To protect frail elders and adults with disabilities from abuse and neglect, DHHS will focus on the following strategies:

Crisis Intervention and Counseling:

- All persons referred to Adult Protective Services are contacted within five days of the referral. Services are provided in coordination with the Crisis Center and the Montgomery County Police Department.
- Funds are being sought to recruit and train volunteer seniors to act as peer counselors for seniors found to be victims of elder abuse. Peer counselors receive 50 to 70 hours of training prior to working with a client.
- Healthy Families Montgomery, a non-profit provider, will maintain home visiting and community services and provide intensive, consistent, long-term, but time limited, services to the elderly and people with disabilities who are at high risk of out-of-home care and neglect. In contrast to abused or neglected children, who may be seen by teachers or friends, mistreated vulnerable adults typically stay hidden in the home or institution and go unreported.

Training:

- All Adult Protective Service staff receive training in emergency petitioning, mental health and confidentiality issues. Ongoing training will be provided in court and guardianship report preparation, substance abuse/alcoholism, mood disorders, depression and service agreements.

- Staff will continue to participate in Maryland State Adult Protective Service seminars and other educational initiatives.
- Train physicians and hospital, police and fire department personnel in identification and reporting of elder abuse and neglect.

Personal Assistance and Respite for Caregivers:

- In-home Aide Services: Expand use of community support systems, such as paraprofessional in-home aides.
- Respite Care: Expand affordable respite care for caregivers through a community coalition consisting of APS, Commission on Aging, Alzheimer's and Parkinson's Associations, and the Stroke Club.
- Mentors: Expand existing successful mentoring programs for caregivers. Develop partnerships with students and seniors through intergenerational programs, such as Interages' pilot project SHARE (Students Help and Reach Elders), with adult day care centers and Montgomery County Public Schools.

Community Education:

- Sponsor Adult Abuse Prevention Week in May as part of a goal to heighten the public's awareness of elder abuse.
- Participate in workshops and community health fairs.
- Speak on local radio and TV stations.
- Speak at retirement and nursing homes.
- Write articles for local newspapers, especially those focused on senior issues, such as *Senior Beacon.*

Community Involvement:

- Efforts are underway to locate funding through the Victims of Crime Act (VOCA) to expand the Shady Grove Adventist Hospital (SGAH) Sexual Abuse and Assault Center to become an adult advocacy center for disabled and elderly women. SGAH presently has a similar program for children and adolescent girls.
- The APS program will work closely with the ombudsman program for nursing homes, group homes and assisted living facilities to improve communication and reporting requirements to the police.
- Increase staff for nursing home inspections.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
AGING AND DISABILITY SERVICES • **Assessment Services**

OTHER HHS PROGRAMS
AGING AND DISABILITY SERVICES • **Continuing Case Management** • **Respite Care** • **In-Home Aide Services** • **Persons with Disabilities Outreach Services** • **Senior Food Program** • **Ombudsman Services** • **Mental Health Services**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE • **Adult Outpatient Mental Health Services**
CRISIS, INCOME, AND VICTIM SERVICES • **24-Hour Crisis Center** • **Prevention and Crisis Intervention**
CHILDREN, YOUTH, AND FAMILY SERVICES
• **Child Welfare Services**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Police	**Department of Developmental Disability Administration (DDA)**	**Alzheimer's Disease and Related Disorders, Association of Greater Washington, DC**
Fire and Rescue Services	**Department of Health and Mental Hygiene (DHMH)**	**Rock Creek Foundation**
County Attorney		**Association of Retarded Citizens**
Montgomery County Public Schools		**Centers for the Handicapped, Inc.**
State's Attorney		**Mental Health Providers**
Housing Opportunities Commission		**Group Home Providers**
		Hospitals and Physicians
		Nursing Homes
		Private Practice Social Workers
		Rehabilitation Facilities
		Commission on Aging

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OUTCOME: Safe Individuals and Families

GOAL: Protect frail elders and adults with disabilities from abuse and neglect.

ASSISTED LIVING

DHHS provides protected living environments for the frail elderly and adults with disabilities using the adult foster care and small group home models. These clients are referred because of mental or physical disability, abuse or neglect, or inability to live independently in the community.

PROGRAM MEASURES

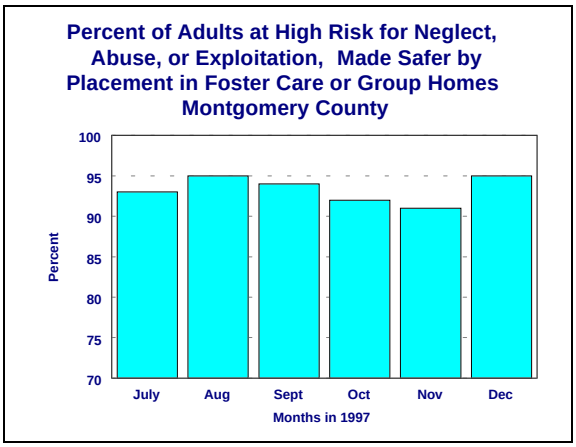
1. Percent of adults at high risk for neglect, abuse, or exploitation, made safer by placement in foster care or group homes.
2. Percent of adults residing in foster care or group homes six and twelve months after placement.

TREND ANALYSIS

HHS began collecting data on the above program measures in July 1997.

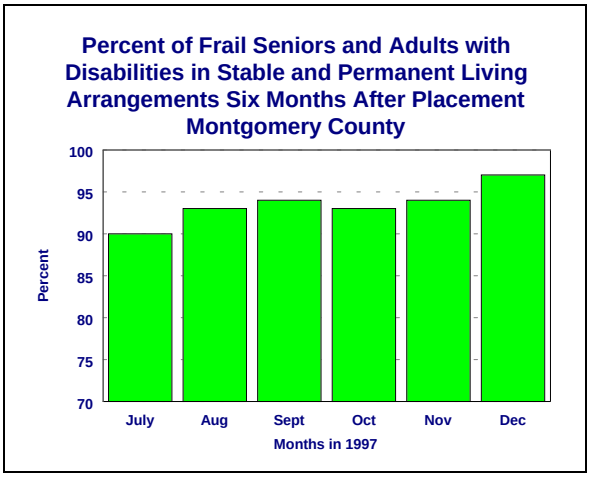
A growing aging population and increased awareness of elder abuse and neglect has resulted in a greater demand for long-term care services. Also, the increasing number of younger people with AIDS and other chronic health disabilities who need supportive housing has had an impact on the long-term care system because traditional options were not designed to meet their needs. Both the cost associated with nursing home placement and people's desire to remain in the community has led to the development of other options for housing people who require assistance. Foster care and group homes are among the options.

Program Measure 1. Percent of adults at high risk for neglect, self-neglect, abuse or exploitation who are made safer by placement in foster care or group homes.



Statistics from July through December 1997 indicate that the percentage of frail elders and adults with disabilities who are placed in foster care or group homes because they are at risk of neglect, abuse or exploitation remained relatively stable (93% to 95%). There are approximately 60 clients in adult foster care and 57 in group homes. As of November 1997, there were 39 people on the waiting list, 24 frail seniors and 15 adults with a disability.

Program Measure 2. Percent of frail seniors and adults with disabilities in stable and permanent living arrangements six months after placement.



The percentage remaining in stable living arrangements six months after placement increased from 90%, or 101 clients out of 112, in July to 97%, or 111 clients out of 114, in December; however it is too early to determine whether this represents a trend.

WHAT WORKS

Studies indicate that adult foster care improves quality of life. Adult foster care is a dynamic and complex enterprise involving emotional, social and health care changes for the participants, caregivers, *and* their families. Programs need to balance flexibility for family and group homes with maintaining desirable standards of care. The recommended model relies on case managers to maintain standards of care by engaging caregivers in a cooperative effort with a professional staff team to improve quality. While studies have focused on family foster care, small group homes provide the same type of protected living environment. The decision to place a client in adult foster care or a group home is based on an assessment of whether a particular client would fare better living with a family or with a small group of peers.

Placement with a committed care provider and social work case management for each resident contributes to the success of both adult foster care and group home placements. Case managers certify and monitor the adult foster care homes and monitor the client's care in group homes. They also help arrange needed services for the caregivers. Types of services include adult day care, occasional in-home aide service, linkage with such activities as job support, representative payee, and training for both providers and residents. One study indicated that at least one type of social service was being used by 80% of caregivers. Monitoring of the homes ensures that standards of care are met. Each resident receives an individual care plan with goals to ensure safety, health, and maximum self-sufficiency. Case management services are crucial to enable these vulnerable adults to remain in permanent and stable housing.

Medication education for care providers helps to ensure that residents are maintained in the same home. A pilot program to improve caregivers' knowledge of medications began in August 1996 and has been extended through FY98. Pre- and post-tests showed that provider comfort with medication and accuracy in medication oversight increased 85%. Further research shows that a professional staff team consisting of a social worker and a nurse should be integrated in the design of adult foster care programs.

STRATEGIES

To increase the percent of adults at risk for neglect, abuse, or exploitation made safer by placement in foster care or group homes, DHHS will:

- Expand funding for adult foster care and group home subsidies for seniors and persons with disabilities. This will help to reduce the waiting list.

- Extend medication education for care providers through FY98.

To maintain the percent of frail seniors and adults with disabilities who remain in permanent living arrangements six months after placement, DHHS will:

- Maintain current case management to ensure that appropriate supports are in place for caregivers and foster care clients.

Program referrals reflect increasingly complex care needs. Often an attempt to provide services is made for an adult whose needs may be too great despite all efforts. During this next fiscal years, data will help identify which strategies increase retention rates.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
AGING AND DISABILITY SERVICES • **Assisted Living Services**

OTHER HHS PROGRAMS
AGING AND DISABILITY SERVICES • **Assessment Services** • **Information and Assistance** • **Community/Nursing Home Medical Assistance** • **Continuing Case Management** • **In-Home Aide Services**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE • **Adult Outpatient Mental Health Services**
CRISIS, INCOME AND VICTIM, SERVICES • **24-Hour Crisis Center** • **Public Assistance Benefits Certification**
PUBLIC HEALTH SERVICES • **Health Promotion and Prevention** • **STD/HIV Prevention and Treatment**
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Welfare Services**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENT OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Public Works and Transportation	**Department of Disability Administration**	**Winter Growth**
Housing Opportunities Commission	**Department of Health and Mental Hygiene**	**Jubilee Association**
Community Development and Housing	**Office on Aging**	**Threshold Services, Inc.**
	Social Security Administration	**Rock Creek Foundation**
		Centers for the Handicapped
		Support Center
		Community Ministry of Montgomery County
		Mar Lyn, Inc.
		Rehabilitative Opportunities, Inc.
		Kennedy Institute
		University Fellowship
		Misler Center
		Shady Grove Adventist Day Care
		Holy Cross Hospital Day Care
		Catholic Charities
		Manor Care at Sligo Creek Day Care
		Randolph Hills Day Care
		Whitman Walker Clinic
		Commission on Aging
		Commission on People with Disabilities

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OUTCOME: Healthy Communities

GOAL: Protect the public from foodborne illness.

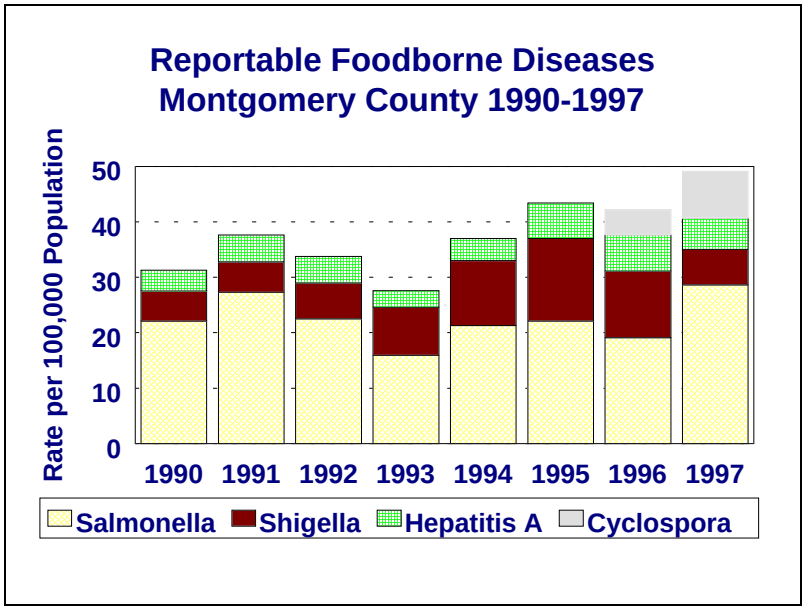
FOODBORNE DISEASES AND ILLNESSES

Foodborne illness protection services address foodborne diseases, such as those caused by Salmonella, Shigella, Hepatitis A, and Cyclospora.

PROGRAM MEASURES

1. Rate of reported foodborne diseases per 100,000 population in Montgomery County.

TREND ANALYSIS



There are several important facts to keep in mind when reading this chart.

- Reportable diseases are those that are most likely to rapidly cause many people to become ill if measures are not taken to prevent their spread.
- Cyclospora is an emerging pathogen, unrecognized and unreported prior to 1996. Currently, Cyclospora reporting by laboratories is voluntary but is included because of a high incidence in the county.
- Reporting is required by laboratories for other emerging foodborne disease pathogens, such as Ecoli 0157:H7 (popularly referred to as the "hamburger disease"). These are not yet included in the graph. However, these emerging pathogens have raised concerns about an increase in foodborne diseases.
- There is consensus among specialists in the field that the reported cases may represent only 10% of the actual incidence of foodborne diseases in the general population.
- Foodborne *illnesses* are not included in this chart because they have not been confirmed with laboratory tests and are therefore not included in the reported *diseases.*

WHAT WORKS

The complexity of managing local outbreaks in a "global marketplace" is extremely challenging. Food is consumed thousands of miles away from where it is grown. This gives organisms the opportunity to travel and infect large numbers of persons over a broad area. The county has also experienced a large influx of foreign-born residents who may have varying degrees of knowledge about food handling and different food preparation standards. In addition, the number of licensed food facilities in this county has increased 46% in the past ten years. There has also been an increase in the reporting of food-related illnesses, likely due to increased public awareness.

Prevention and Education

Contamination of food sources is a problem which requires national surveillance and coordination and cannot be addressed solely by the local community. However, actions by individual residents as well as food-related facilities can reduce foodborne illness. Proper personal hygiene, and food storage and preparation methods are effective in reducing the incidence of foodborne illness.

To prevent foodborne illness, DHHS provides consumer information and inspects and licenses all food facilities. In addition, in 1989 Montgomery County began mandatory training in safe food handling for all food service establishments and requires that one trained person be on the premises at all times.

Continuing staff education and communication with other jurisdictions on emerging pathogens is critical. In 1996 Public Health Services staff participated in the nationwide Cyclospora work group of the Centers for Disease Control and Prevention. This knowledge helped to contain the 1997 Cyclospora outbreak in Montgomery County.

Surveillance and Emergency Response

The Environmental Health Regulatory Services Program of Public Health Services inspects and issues permits for food facilities in Montgomery County to assure compliance with health and safety standards. When an outbreak reaches a certain severity and magnitude, the Centers for Disease Control and Prevention (CDC) in Atlanta dispatch Epidemic Intelligence Service Officers. In the past year, the CDC sent officers to assist with three outbreaks in the county.

When an outbreak occurs in Montgomery County, a prompt assessment and investigation of foodborne complaints by a professional community health nurse from the Communicable Disease, Epidemiology and Lab Services program identifies the urgency of risk and allows measures to be instituted to control spread before large numbers of people are affected. Persons who are already ill are directed to appropriate care so diagnosis and treatment begins early, which decreases the chance of spread to other household and family members.

STRATEGIES

In order to protect the residents of Montgomery County from foodborne illness, DHHS will focus on the following strategies:

- Initiate a coordinated program of education and control to decrease foodborne illness with Communicable Disease, Epidemiology and Lab Services, Health Promotion and Prevention, and Environmental Health Regulatory Services as partners.
- Continue inspections of food facilities.
- Increase staff for restaurant inspections and rodent control.
- Educate those concerned about a current illness or exposure about the specific diseases, precautions and information on safe food-handling practices, to reduce spread of disease
- Provide seasonal/holiday media education to inform residents about safe food handling.
- Educate school-aged children and their families about proper hygiene and food handling, through newsletters and parent information articles.
- Continue Medical Alerts to local hospital emergency rooms and infection control practitioners when outbreaks occur that affect the general community.
- Coordinate with other community groups to maximize public education efforts.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
PUBLIC HEALTH SERVICES • **Communicable Disease, Epidemiology and Lab Services**

OTHER HHS PROGRAMS
PUBLIC HEALTH SERVICES • **Environmental Health Regulatory Services** • **Health Promotion and Prevention**
ADMINISTRATION AND SUPPORT • **Accountability and Customer Service**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT AGENCIES/DEPARTMENTS*	*OTHER PARTNERS*
Environmental Protection	**Maryland State Department of Health and Mental Hygiene**	**Print, Radio and Broadcast Media**
Regional Service Centers	**The Centers for Disease Control and Prevention**	**Local Hospitals**
Economic Development	**Health Departments in the Washington Metro area**	**Nursing Homes**
	University of Maryland, Cooperative Extension Services	**Infection Control Practitioners**
		Restaurants
		Chambers of Commerce

OUTCOME: Healthy Communities

GOAL: Prevent the spread of tuberculosis.

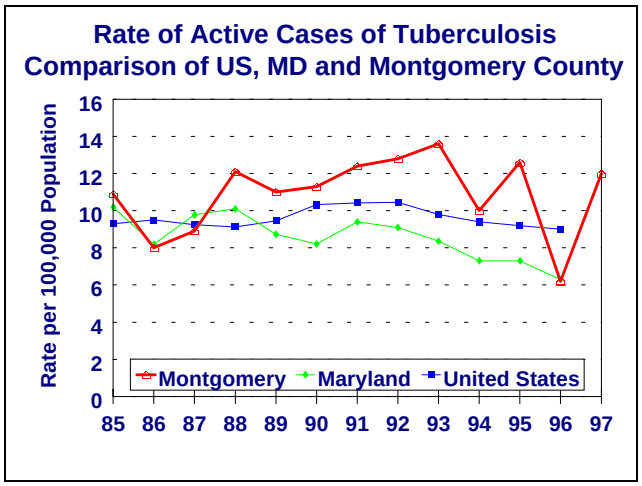
TUBERCULOSIS CONTROL

Tuberculosis (TB) is a chronic debilitating infectious disease spread through close contact with airborne droplets from actively infected persons. To control the spread of tuberculosis, DHHS provides testing, treatment and preventive services.

PROGRAM MEASURES

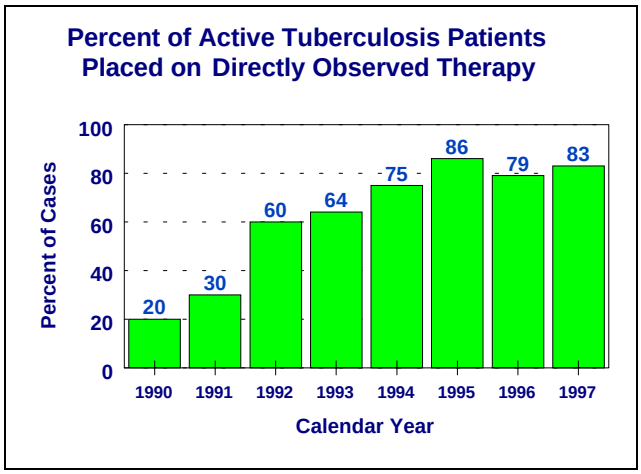
1. Percent of active TB patients placed on directly observed therapy (DOT).

TREND ANALYSIS



Historically, TB rates in Montgomery County have been high in relationship to the statewide and national rates. In 1996, the rate fell drastically but in 1997 the rate rose to nearly the 1995 rate. One of the reasons for the high and fluctuating rates in Montgomery County may be due to the sporadic nature of immigration patterns from countries where TB is more prevalent. In Montgomery County, 84 percent of TB cases have been found in residents born outside the United States. The current case rates for county residents born in the United States are very low. Strong public health infrastructures have resulted in very low transmission of contagious TB cases to the general public.

Program Measure 1: Percent of active TB patients placed on directly observed therapy.



- Residents found to have active TB are given four medications to be taken daily. If treatment is not completed, these cases of TB become resistant to the treatment drugs and are very difficult to treat. To ensure that patients complete treatment, DHHS implemented directly observed therapy (DOT). Directly observed therapy means that DHHS staff watch the client take the medications every day until the course of treatment is completed, usually six months.

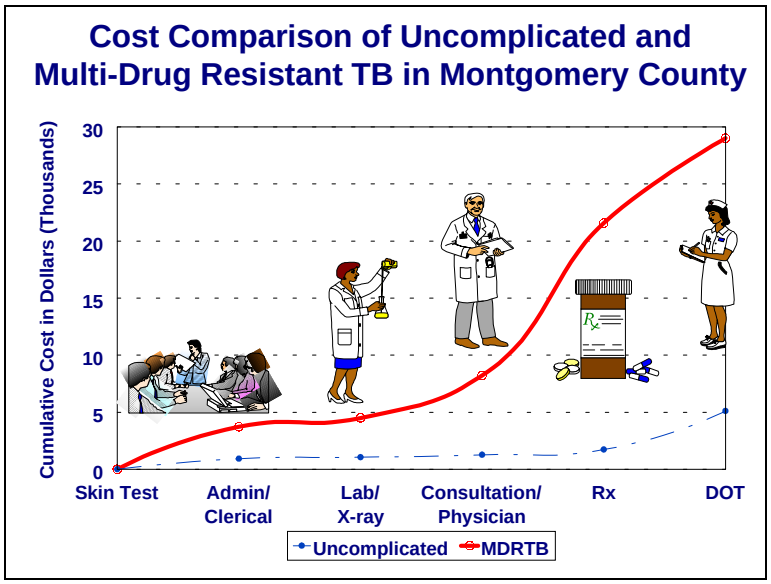
- The percent of patients placed on directly observed therapy steadily increased from 20% in 1990 to 83% in 1997. The ultimate goal is to place as many TB cases on DOT as possible. Those who test positive on a TB screening test but do not have active TB are offered preventive treatment. It is also a goal to place as many of these individuals as possible on directly observed preventive therapy (DOPT).

- One hundred percent of clients placed on DOT either complete treatment or are transferred to other health care providers if they move from Montgomery County.

WHAT WORKS

Directly observed therapy has been found to improve treatment completion rates, and thereby has a positive impact on the TB rate. Clients who do not complete treatment are at greater risk of developing TB that is resistant to existing treatment drugs. Multi-drug resistant TB (MDRTB) is more complex and costly to treat and has a lower cure rate--50% to 60% versus 95% to 100% for those without the multi-drug resistant type.

Directly observed therapy has been proven to be the most reliable and cost-effective means of treatment and eliminates the need for costly hospitalization or confinement. Since tuberculosis is a contagious life-threatening disease that requires appropriate and prolonged treatment, it is the responsibility of public health officials to assure that all patients complete treatment so as to limit the spread of this disease. Although DOT is labor-intensive, the cost of proper treatment now is 10% of the cost of treating a multi-drug resistant case in the future. The fact that there has been only one case of multi-drug resistant TB reported in Montgomery County to date can be attributed to the effectiveness of the DOT program.



Note: The above chart illustrates the increase in cost of more intensive treatment required for multi-drug resistant tuberculosis. The average cost of treating an uncomplicated TB case is $5,114 per case compared to $27,007 for a multi-drug resistant case. This cost comparison does not include the cost of hospitalization which further increases treatment cost.

In addition to DOT, the following are effective in controlling TB:

- Involving patients in, and educating patients about, their own TB care plan.
- Educating the general public and public/private health care providers.
- Early reporting of TB suspect/active cases by health care providers and regional TB laboratories.
- Surveillance screening and preventive therapy for TB in high-risk groups, with emphasis on a high completion rate for preventive therapy.
- Nurse case management of all active cases, including patients under private physician care.
- Regional case management of TB patients who work in Montgomery County but reside elsewhere.

STRATEGIES

To prevent the spread of tuberculosis, DHHS will:

- Continue to provide DOT to any Montgomery County resident with active TB regardless of financial or immigration status.
- Increase its efforts to work with private physicians to encourage their patients to agree to participate in DOT.
- In recognizing that TB is a regional problem ," a disease without borders," Montgomery County will continue to take the lead in a partnership with the Metropolitan Washington Council of Governments Health Officers Committee, Tuberculosis Subcommittee, to address issues in TB control. The goals are to strengthen the infrastructure for surveillance and tracking of TB cases, to increase communication, and to develop an intra-jurisdictional approach to TB case management. Another goal is to continue to support the regional surveillance agreement signed by the mayor of the District of Columbia and TB control officials in the metropolitan region on April 11, 1997.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
PUBLIC HEALTH SERVICES • **Tuberculosis Services**

OTHER HHS PROGRAMS
ADMINISTRATION AND SUPPORT • **Accountability and Customer Services**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES • **Addiction Services Coordination**
CHILDREN, YOUTH, AND FAMILY SERVICES • **School Health Services**
PUBLIC HEALTH SERVICES • **Health Promotion and Prevention** • **Enviromental Health Regulatory Services** • **STD/HIV Prevention and Treatment** • **Dental Services** • **Communicable Disease, Epidemiology and Lab Services**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Office of Human Resources • **Occupational Medical Services**	**Department of Health and Mental Hygiene (DHMH)**	**HOSPITALS** • **Shady Grove Adventist** • **Washington Adventist** • **Holy Cross** • **Montgomery General** • **Suburban** • **National Naval Medical Center**
Correction and Rehabilitation Department • **Detention Center**	**Health departments in the metropolitan area and the nation**	**CLINICS** • **Community Clinic** • **Mobile Medical Care, Inc.**
	Metropolitan Washington Council of Governments	**Local pulmonologists and private medical doctors**
	Center for Disease Control and Prevention (CDC)	**Long-term care facilities**
		CBOs (Lung Association) [spell out]
		Spanish Catholic Center
		Indochinese Community Center
		Health Care for the Homeless
		National Coalition for the Elimination of TB
		EMTs
		Second Genesis, Inc.
		Avery Road Treatment Center

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OUTCOME: Safe Individuals and Families
Healthy Adults
Economically Secure Individuals and Families

GOALS: ***Reduce harm to individuals, families and the community from substance abuse disorders.***
Increase an individual's and family's ability to be self-sufficient.

ADULT ADDICTION SERVICES

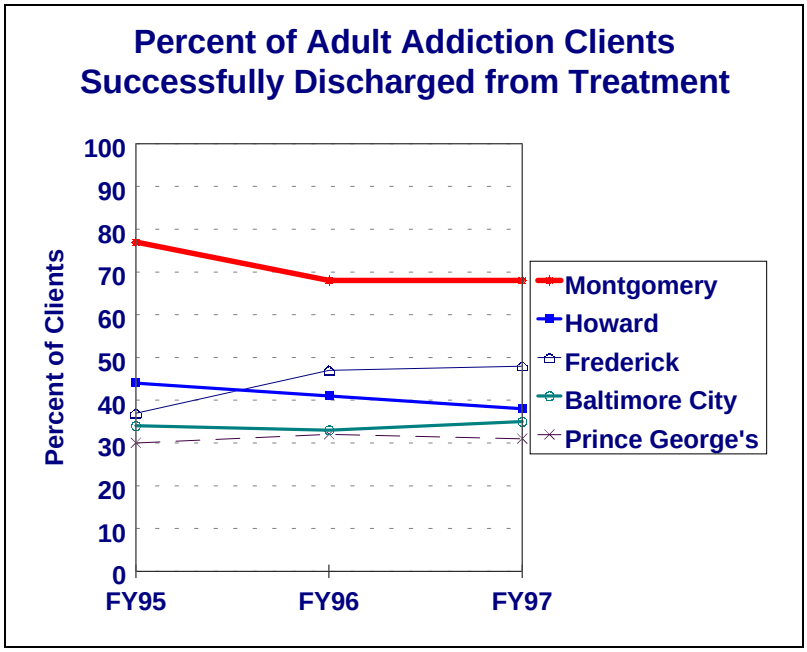
Adult addiction services is a comprehensive system of community and correctional-based substance abuse screening, assessment and treatment. Services are organized as an integrated continuum of care using standardized screening, assessment and patient placement criteria.

PROGRAM MEASURES

1. Percent of clients successfully discharged from treatment.
2. Percent of clients referred from the criminal justice system.

TREND ANALYSIS

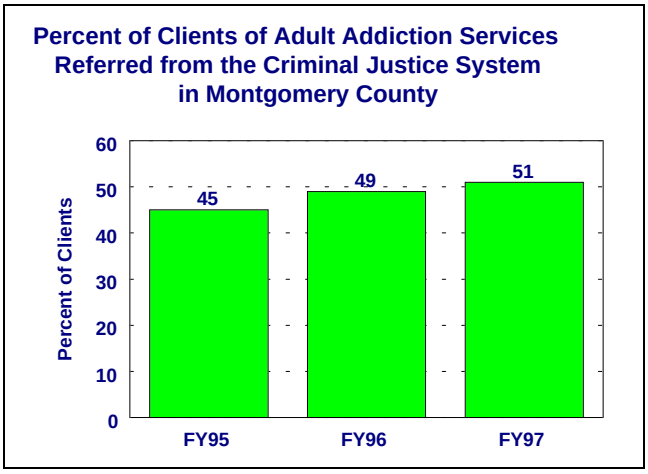
Program Measure 1: Percent of clients successfully discharged from treatment.



Note: "Successfully discharged" is based on criteria set by the Maryland State Department of Health and Mental Hygiene. Discharge categories considered to be successes include: 1) completed treatment--no substance use; 2) completed treatment--some substance use; 3) did not complete treatment--referred; 4) completed treatment plan--referred; and 5) change in service within episode.

Montgomery County has the highest treatment discharge success rate in the state, 68%, compared to Frederick County, which ranked second with a 48% successful discharge rate.

Program Measure 2: Percent of clients referred from the criminal justice system.



- Criminal justice and addiction research indicates that combining criminal justice supervision and addiction treatment in a program of graduated sanctions controls an offender's behavior in the community so that an effective amount of treatment can be delivered. Priority is therefore given to clients of social institutions that provide built-in motivation for clients to engage in and sustain treatment--e.g., criminal justice, Temporary Cash Assistance (TCA), and child welfare.
- DHHS has made a special effort to increase the number of clients who are involved in the criminal justice system, increasing the percentage served from 45% of all clients in FY95 to 51% in FY97.

WHAT WORKS

Two factors consistently point to improved outcomes for individuals with substance use disorders: length of time in treatment (retention) and the relationship between external coercion and retention in treatment. The criminal justice system, or any social system which can place controls on an individual's behavior, are natural points to offer addictions treatment. The sanctions and incentives provided for TCA and child welfare clients to participate in addictions treatment are expected to get and keep more people in treatment.

Individuals who stay in treatment the longest are those involved in the criminal justice system. A two-year outcome study of the Jail Addiction Services (JAS) program in Montgomery County proved the effectiveness of this strategy. Participation in JAS reduced the probability of reoffending by 45%. Participation in community-based treatment after JAS, which lengthens the time in treatment, reduced the odds of recidivism by over 75%.

Substance use disorders exist on a continuum. Successful treatment requires matching treatment to the individual's level of need. The American Society of Addiction Medicine Patient Placement Criteria, Second Edition (ASAM, PC II) provides a classification system based on medical necessity criteria, matching patients to levels of needed treatment intensity. A public treatment system, serving the needs of clients in the criminal justice, child welfare or Temporary Cash Assistance systems, as well as clients who are medically indigent, must consider not only medical criteria but also social necessity criteria. If not properly treated, clients with addictive diseases will default to the care of other programs funded by the county that are not equipped to handle these disorders.

STRATEGIES

To increase the rate of clients successfully completing treatment, DHHS will focus on the following in FY99:

- Continue to refine with the District and Circuit Courts and the Division of Parole and Probation the graduated sanctions program, a program that manages noncomplying offenders by gradually increasing sanctions for noncompliance.
- Continue implementation of the HIDTA Automated Treatment and Tracking (HATTS) information system, which links parole and probation with the addiction system, is planned to better manage the care of offenders in community-based supervision and to track outcomes.
- Increase county funding for MATER (Mothers and Tots Entering Recovery) program to provide day treatment for mothers with substance abuse problems who have young children.
- As changes in welfare and child protection have occurred, integrating addiction treatment into the strategies used has become essential. Time-limited welfare, or TCA, is intended to motivate recipients to move to self-sufficiency. If the recipient has a substance use disorder, welfare reform requires participation in addiction treatment as a condition of participation in TCA. Noncompliance results in a reduced benefit. In child protection cases, addiction treatment services are provided when needed. In both TCA and child protection situations, the respective social systems are placing controls (external coercion) on an individual's behavior so that an appropriate dose of treatment can be delivered.

To improve integration of addiction treatment services with child welfare and Temporary Cash Assistance services, DHHS will focus on the following in FY99:

- In collaboration with Child Welfare Services, develop and implement a structured responses program for child welfare clients needing addiction treatment, similar to the graduated sanctions program but including rewards for compliant behavior as well as sanctions for noncompliant behavior. This effort will result in better outcomes for these clients.
- Continue implementation of a structured responses program for TCA program recipients. This approach identifies TCA clients with substance abuse disorders and refers them for assessment and treatment.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES • **Addiction Services Coordination** • **Jail Addiction & Community Re-Entry Services** • **Outpatient Addiction Treatment**

OTHER HHS PROGRAMS
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES • **Adult Outpatient Mental Health Services**
PUBLIC HEALTH SERVICES • **Community Health Nursing** • **Health Promotion and Prevention** • **Communicable Disease, Epidemiology, and Lab Services** • **STD/HIV Prevention and Treatment**
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Welfare Services**
CRISIS, INCOME, AND VICTIM SERVICES • **Prevention and Crisis Intervention** • **24-Hour Crisis Center** • **Public Assistance Benefits Certification**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Correction and Rehabilitation	**Alcohol and Drug Abuse Administration**	**Potomac Healthcare Foundation**
Police	**Division of Parole and Probation**	**Ethos Foundation**
Housing Opportunities Commission	**District Court of Maryland for Montgomery County**	**Guide, Inc.**
Public Works and Transportation	**Circuit Court of Maryland for Montgomery County**	**Montgomery General Hospital**
		Suburban Hospital
		Second Genesis, Inc.

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OUTCOME: Young People Making Smart Choices

GOAL: Increase self-sufficiency by improving educational and vocational skills.

VOCATIONAL SKILLS DEVELOPMENT

The Montgomery County Conservation Corps (MCC) is a 13-year-old program that offers county residents age 17 through 24 who are out of school and unemployed an opportunity for paid on-the-job training in conservation, carpentry, landscaping and urban maintenance. Corps members are taught basic work habits and life skills.

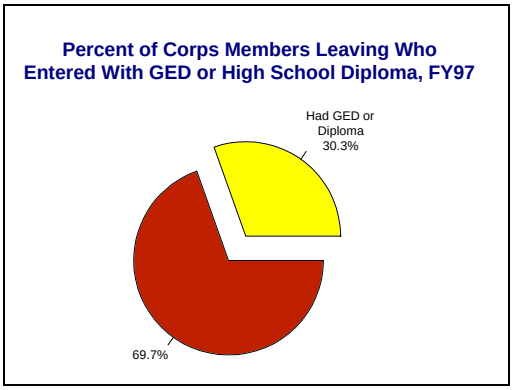
PROGRAM MEASURES

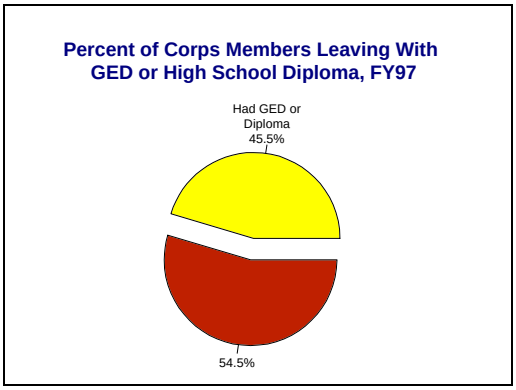
1. Percent of corps members leaving the program who attained a GED or high school diploma.
2. Percent of corps members leaving the program who entered the job corps, returned to school, or got a job.

TREND ANALYSIS

The Conservation Corps began in 1984 as an opportunity for young adults to give a year of service to maintain and protect the environment. The focus has now changed to providing educational and vocational skills development for young people who lack access to mainstream career opportunities. The current corps members are mostly high school drop-outs whose skill deficits limit their opportunities to move into stable careers. In FY97, there were 33 corps members who left the program, 79% of whom were male, 58% African American, 22% Caucasian, 12% Latino and 8% Asian American.

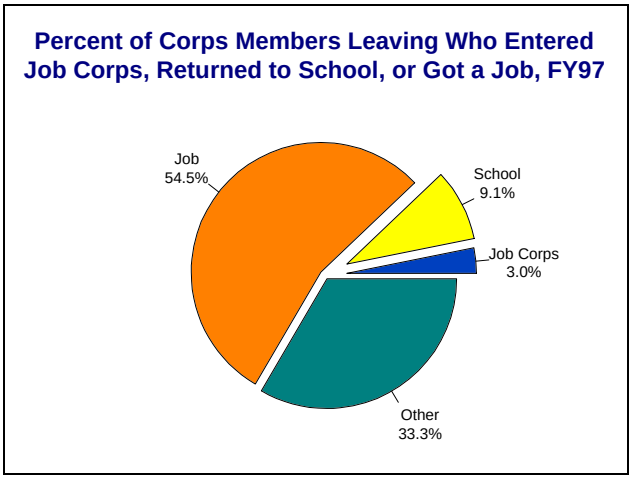
Program Measure 1. Percent of corps members leaving the program who attained a GED or high school diploma.





- Of the 33 corps members who completed and left the program in FY97, one had entered the program with a GED and nine had already earned high school diplomas, which was 30.3 % of the members.
- By the end of FY97, five additional members had earned a GED.
- Of these 33 corps members, the final number who completed the program with a GED or high school diploma was 15, which is 45.5% of the members. This represents a 50% increase.

Program Measure 2. Percent of corps members leaving the program who entered the job corps, returned to school, or got a job.



- In FY97, of the 33 corps members who left the program, 66.7% had a successful outcome--one joined the job corps (3%), three returned to school (9.1%), and 18 (54.5%) were placed in jobs.

WHAT WORKS

The juvenile justice literature emphasizes the importance of an employment component in prevention programs. By late adolescence, employment is a crucial factor in development and one of the most important predictors of later adjustment. Yet employment is arguably the least consistently addressed component in conventional interventions with delinquent youth. Evaluation of a 1960s job corps program similar to the Conservation Corps and other employment-centered prevention programs in the 1970s demonstrated success in preventing serious, violent crime. What all of these successful programs have in common--and what seems to account for their effectiveness--is the solid focus on a real job or serious skills training combined with intensive support services. Studies also show that programs tend to work better if they serve a diverse population.

Abt Associates, a nationally recognized social research and evaluation organization, has conducted a national study of state and local youth service and conservation corps programs. The study found that the communities where the corps do service projects reported high customer satisfaction with the work performed, indicating the quality of the vocational skills developed by participants. The study also showed dramatic positive results for participants in the corps, particularly for African-American young men. The study reported that African-American men who participate in the corps work more, earn more, vote more often, and earn more associate degrees than a comparable group of men. The study found that young people who participate in the corps are less likely to be arrested. These findings indicate that the corps increases self-sufficiency and encourages positive life choices.

STRATEGIES

To increase self-sufficiency by improving the educational and vocational skills of members, the Conservation Corps will:

- Reinstate corps member development services--support counseling, life skills training, field trips, job search training, and job skills classroom training--to 65% of levels before fee-for-service began.

- Improve the demographic mix of corps members to broaden expectations and life experiences. The corps will attempt to enroll more young adults with a high school diploma, perhaps some college, and increase the enrollment of women.

- Add a full crew to the corps, funded through welfare reform reinvestment dollars, to provide employment and training alternatives for current Temporary Cash Assistance recipients.

- Continue the effort begun in 1997 to forge a partnership with the Workforce Development Corporation, Montgomery Youth Works, and Montgomery County Public Schools to address the underserved out-of-school youth with multiple barriers to career employment and productive citizenship.

- Upgrade computer systems to implement an automated reporting system that will reflect corps members' demographic characteristics, achievement milestones and post-corps outcomes.

- Seek funding to begin a project to provide job placement and support activities for former corps members and implement a formal tracking process on corps program graduates.

- Continue a partnership recently developed through Montgomery's Promise to bring more corporate support to the corps program to increase job placement and internship opportunities.

- Seek funding to offer U.S. Savings Bonds as an incentive for earning a GED and graduating from the corps.

- Obtain resources for job search workshops.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
CHILDREN, YOUTH, AND FAMILY SERVICES • **Conservation Corps**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT AGENCIES/DEPARTMENTS*	*OTHER PARTNERS*
Montgomery County Public Schools	**National Park Service**	**Career Connections**
	Maryland Department of Human Resources/ Family Investment Administration	**National Association of Service and Conservation Corps**
		Friends of the MCC Board
		Workforce Development Corporation
		Montgomery Youth Works

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OUTCOME: Economically Secure Individuals and Families

GOAL: Support economic self-sufficiency among low-and moderate-income families.

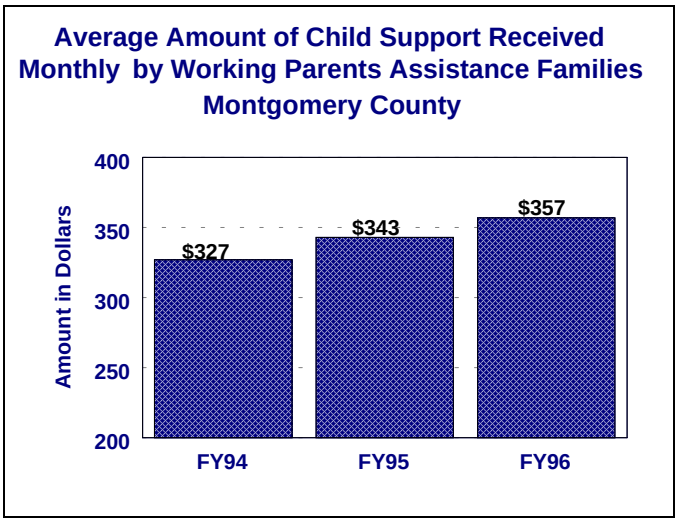
CHILD CARE SUBSIDIES

Child care subsidies are provided to enable parents to obtain and maintain employment, thereby becoming more self-sufficient. DHHS administers two child care subsidy programs. The state funded Purchase of Care (POC) program provides child care subsidies for only the lowest-income families; including those receiving Temporary Cash Assistance (TCA) benefits, formerly known as " Aid to Families with Dependent Children" (AFDC), and commonly referred to as " welfare," and other eligible residents. For those low- and moderate-income families whose income exceeds the eligibility requirements for TCA, the county funds its own child care subsidy program, called the Working Parents Assistance (WPA) program. Applicants for each of these subsidy programs are required to pursue child support payments, if eligible, as another means of reaching economic self-sufficiency.

PROGRAM MEASURE

1. Average amount of child support received by families receiving child care subsidies.

TREND ANALYSIS



- From FY94 to FY96, the average amount of child support received monthly by Working Parents Assistance families increased from $327 to $357. Applicants are required to pursue child support payments if they are eligible to receive them. Efforts include follow up by staff to assure compliance and assistance to participants in the process. Approximately 88% of the WPA applicants have child support orders in place and 53% of those are receiving payments at this time. This measure is an indicator of increasing family self-sufficiency.

- In 1996, WPA recipients earned total income of $16.5 million. WPA families paid a total of $2.6 million in taxes and the total subsidy paid was $2.4 million. This information is not available for the state-funded Purchase of Care program but is being collected and will be available next year.

- The Working Parents Assistance and Purchase of Care programs served between 1,500 to 2,000 families annually from FY94 to FY96. In October 1997, the Purchase of Care program transferred $1.6 million in surplus funds to the WPA program to help reduce its waiting list of 750 children. The surplus was due to lower than adequate rates being paid in the POC program prior to that time.

WHAT WORKS

- The success of reforms in welfare will be dependent on the ability of Temporary Cash Assistance recipients to obtain affordable child care in order to search for and maintain employment. Research indicates that child care subsidies are one of the most effective strategies to assist parents to obtain and retain employment. Highly successful programs in Ottowa County, Michigan and Anne Arundel County, Maryland provide child care subsidies for parents who are seeking work or working as a strong component of the counties' strategy to assist parents in their efforts to work. By gaining work experience, recipients improve their chances of increasing their earning capacity and become more economically secure.

- Although the ultimate goal is to keep parents employed so that their income will increase to the point where they no longer require child care subsidies, some families may continue to need some level of subsidy over an extended period due to conditions beyond their control, such as the high cost of child care in Montgomery County relative to wages, or a low educational level or disability which hampers advancement. It is hoped, however, that they will increase their earned income to require a lower level of subsidy. The barriers to full self sufficiency for any families unable to increase their income enough to leave the subsidy program will continue to be monitored.

STRATEGIES

To promote economic self-sufficiency of low-income families, DHHS will:

- Continue to require that applicants for the Working Parents Assistance and Purchase of Care programs pursue child support and will counsel single parents about the importance of child support.

- Expand coordination between the Child Care Services program and the Montgomery County Office of Child Support Enforcement, which is administered through the circuit court, to collect payments.

To track whether child care subsidies help families move toward greater economic self-sufficiency, DHHS will:

- Create a new database to record the amount of child support received by recipients of the state-funded Purchase of Care program.

- Create a system to track how many recipients successfully increase their incomes so they are no longer eligible for POC but are still eligible for WPA, and then finally have sufficient income that they no longer require any subsidies.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Care**

OTHER HHS PROGRAMS
CRISIS, INCOME, AND VICTIM SERVICES • **Prevention and Crisis Intervention** • **Public Assistance Benefits Certification** • **Partner Abuse Services**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE • **Addiction Services Coordination** • **Outpatient Addiction Treatment**
PUBLIC HEALTH SERVICES • **Care for Kids Program**
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Welfare Services** • **School Health Services**

Other partners who contribute to the outcomes:

OTHER COUNTY DEPARTMENTS OR AGENCIES	OTHER GOVERNMENT DEPARTMENTS OR AGENCIES	OTHER PARTNERS
Montgomery County Public Schools: • **Head Start**	**Department of Human Resources (DHR):** • **Child Care Administration** • **Child Support Enforcement Administration** • **Family Investment Adminstration**	**MAXIMUS Corporation**
Housing Opportunities Commission		**Maryland Dept. of Labor, Licensing and Regulation**
Sheriff • **Child Support Enforcement**		**Child Care Connection**

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OUTCOME: Young People Making Smart Choices

GOALS: ***Reduce teen pregnancy.***
Ensure the health of babies born to teen parents.
Promote economic security for teen parents and their babies.

TEEN PARENT SUPPORT

Teen Parent Support Teams (TPST) were created to reduce teen pregnancy, ensure the health of babies born to teen mothers, and encourage pregnant girls to remain in school and postpone additional pregnancies. The teams serve 13 high schools and offer an array of services through DHHS, Montgomery County Public Schools (MCPS) and community agencies. The Montgomery County Interagency Coordinating Committee on Adolescent Pregnancy Prevention and Parenting (ICCAPPP) serves as a resource for additional services.

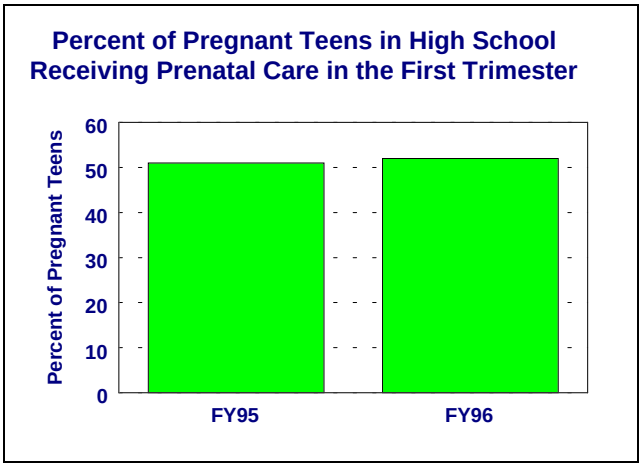
PROGRAM MEASURES

1. Percent of pregnant teens in high school receiving prenatal care in the first trimester.
2. Percent of all infants born to high school teens that are of low birth weight (5.5 pounds or 2,500 grams).
3. Percent of repeat pregnancies among high school teen participants within 12 months.
4. Percent of pregnant or parenting teens among program participants who complete the current school year, graduate, or receive a GED.
5. Percent of infants born to high school students for whom legal paternity has been established.

TREND ANALYSIS

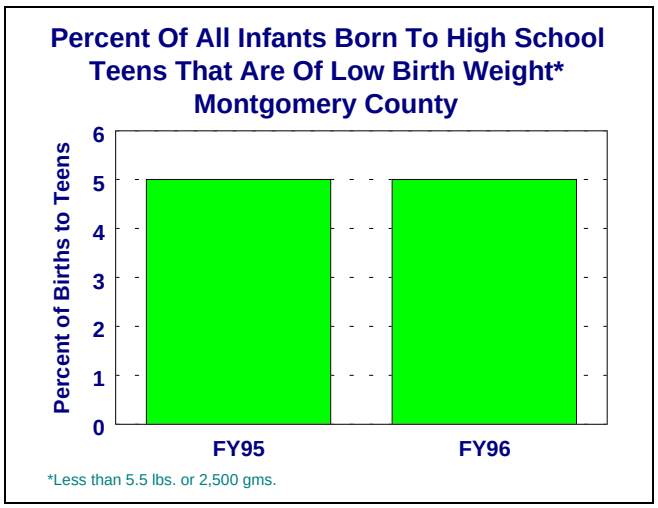
Births to county residents under age 18 have ranged from 15 to 18 per 1,000 females age 13 to 18 from 1985 to 1995, the most recent year figures are available. The county rate in 1995, at 18 births per 1,000, was lower than the statewide rate of 44 births per 1,000.

Program Measure 1. Percent of pregnant teens in high school receiving prenatal care in the first trimester.



Prenatal care in the first trimester is recommended to ensure healthy mothers and babies. Adolescent mothers are less likely than older mothers to get prenatal care early. They are also at increased risk of insufficient weight gain and poor nutrition during pregnancy and many adolescent mothers are at greater risk of delivering a premature or low birth weight infant. In FY95, 51% and in FY96, 52% of Montgomery County pregnant teens in high school received prenatal care in the first trimester.

Program Measure 2. Percent of all infants born to high school teens that are of low birth weight (5.5 pounds or 2,500 grams).

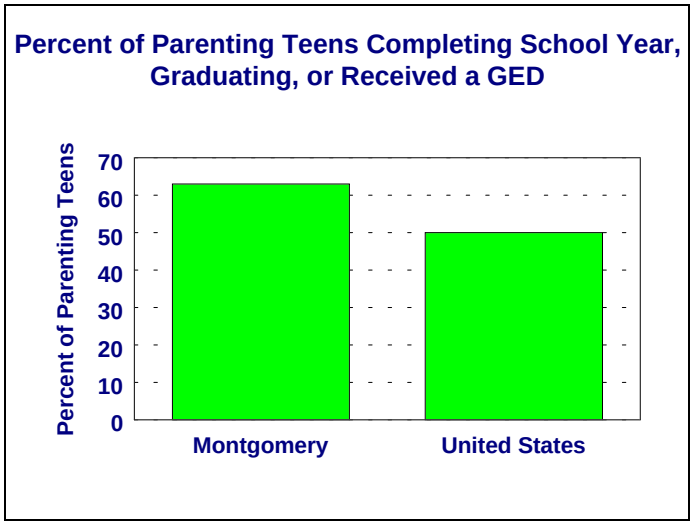


The percent of low weight babies among births to teens did not change significantly between FY95 and FY96.

Program Measure 3. Percent of repeat pregnancies among high school teen participants within 12 months.

TPST data for 1995-96 show that of the 45 teen mothers participating in the program, only one had a repeat pregnancy within 12 months after delivery.

Program Measure 4. Percent of pregnant or parenting teens among program participants who completed the current school year , graduated, or received a GED.



Montgomery County Teen Parent Support Team 1995-1996 data show that of 45 participants, 63% remained in school, graduated or received a GED. The national school drop-out rate for teen mothers is 50%. Teen parents who stay in school are almost as likely (73%) to graduate as girls who do not become mothers while in school(77%). Analyses among high school-age mothers in the National Educational Longitudinal Study show that involvement in school activities after the birth of the first child, or receipt of a high school diploma or a GED, were strongly associated with postponing a second teen birth.

If a teen parent does not complete her education, her employment prospects are limited to low-paying jobs so there is little incentive to get off public assistance. In addition to the personal cost of teenage childbearing there is significant public cost. In 1997, it was estimated that 53% of the funds from the AFDC program (now known as the Temporary Cash Assistance Program) were spent directly as a result of adolescent childbearing. In 1992, (the last year for which data have been analyzed), the Maryland pay-out of all benefits for a "typical" female head of household and two children under 18 was $1,426/month, or $17,112 annually.

Program Measure 5. Percent of infants born to high school students for whom legal paternity has been established.

> Data will be collected in FY 98. Under new welfare requirements, mothers are required to establish paternity for eligibility for most children's benefits.

WHAT WORKS

The National Campaign to Prevent Teen Pregnancy notes there has been little investment in evaluating the effectiveness of programs to prevent teen pregnancy. In addition, it asserts that most current research available does not employ sound scientific methods due to errors, such as a too small sample, lack of comparison groups, lack of long-term follow-up and lack of replication of findings. However, two current scientifically sound studies have recently been published in the *Journal of the American Medical Association.* Both studies examined the effects of prenatal and post-partum home nurse visits to first-time, low-income mothers on birth and child-rearing outcomes. The home visits focused on parenting skills, prenatal care, nutrition, child abuse prevention and child health education. One study involved 400, mostly white mothers, living in semi-rural Elmira, New York; the other involved just over 1,100, mostly African American mothers, living in urban Memphis, Tennessee.

The Elmira study found that home visits by nurses during prenatal and early childhood years reduced repeat pregnancies, use of welfare, child abuse and neglect for up to 15 years after birth of the first child. Mothers with home nurse visits who smoked at the beginning of pregnancy had 75% fewer pre-term deliveries than the comparison group. Teen participants delivered babies with higher birth weights than the comparison group.

The Memphis study found home nurse visits reduced pregnancy-induced hypertension, childhood injuries, repeat pregnancies and the use of AFDC among participants. It also found nurse-visited women attempted to breast-feed more often and provided home environments that were more conducive to a child's intellectual and socio-emotional development.

The National Campaign to Prevent Teen Pregnancy also notes that effective strategies for teen pregnancy prevention must address male responsibility. An important first step is increasing the number of fathers who acknowledge paternal responsibility. New Jersey has taken an innovative approach in having males accept paternal responsibility by asking unmarried fathers in the hospital immediately after delivery to voluntarily acknowledge paternity. The state pays hospitals incentive funds of $10-$20 per

acknowledgment through the Paternity Opportunity Program (POP). In the two years since its inception, paternity acknowledgment rates have jumped from 21% to 74%, which is well above the national average of 30%.

STRATEGIES

- Teen Parent Support Teams are part of a comprehensive strategy which includes an entire network of services and partners. Home visits are shared by the DHHS school-based and community-based health nurses assigned to the high schools and those described in the following item.
- The DHHS Healthy Families program provides intensive home-based services to first-time mothers who are at high risk of child abuse or neglect. Services are provided by social workers from Family Services, Inc. and DHHS community health staff.
- Mentoring for Teen Mothers. MOMS Mentoring Program**,** a Mental Health Association program, matches teen mothers with an adult mentor. In 1996 all of the participants who had been in the program for more than one year were currently in school, graduated or received a GED, and none had experienced a repeat pregnancy.
- Mentoring for Teen Fathers**.** DADS**,** a Mental Health Association program, matches teen fathers with an adult mentor. In 1995-96, 45% of the active teen fathers received a high school diploma or GED, 50% were employed and no new pregnancies were reported.
- Analyze data collected by school nurses on pregnant students to evaluate the effectiveness of Teen Parent Support Teams.
- Expand Teen Parent Support Teams from 13 high schools to any high schools requesting the resource.
- Expand collaboration with public and private partners.
- Expand school and community health nursing collaborations with Healthy Start case management.
- Target high-risk groups, especially middle school children and teens in foster care.
- Provide a clearinghouse for resource referrals.
- Expand multicultural outreach.
- Advocate for higher income eligibility limits to expand child care voucher eligibility for low-income parents.
- Enhance nutrition education for pregnant and parenting teens.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
CHILDREN, YOUTH, AND FAMILY SERVICES • **School Health Services**

OTHER HHS PROGRAMS
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Care** • **Child Welfare Services**
PUBLIC HEALTH SERVICES • **Communicable Disease, Epidemiology, and Lab Services** • **Immunization Services** • **STD/HIV Prevention and Treatment** • **Community Health Nursing** • **Women's Health Services** • **Health Promotion Prevention**
CRISIS, INCOME, AND VICTIM SERVICES • **Public Assistance Benefits Certification**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Montgomery County Public Schools • **Comprehensive Pupil Services** • **Home Economics Program** • **Home and Hospital Teaching**	**City of Rockville** • **Youth, Family and Community Services**	**Montgomery County Interagency Coordinating Committee on Adolescent Pregnancy Prevention and Parenting (ICCAPPP)**
	Montgomery College • **Project Next Step Work/Study Program**	**Florence Crittenton Services of Greater Washington** • **Montgomery County Community Health Partnership** • **PEARLS Program**
		Child Care Connection Program • **Family Works Program**
		Early Head Start Programs
		Planned Parenthood of Metropolitan Washington, DC, Inc.
		CYGMA Health Services
		Youth Services Agencies • **B-CC YMCA's Bethesda Youth Services** • **GUIDE Youth Services** • **Olney, Gaithersburg, Upcounty** • **Kensington/Wheaton Youth Services** • **Silver Spring Youth Services**
		Community Clinic • **Women, Infants and Children Nutrition Program**
		Mental Health Association of Montgomery County • **MOMS Program** • **DADS Program**
		Adventist Health Care Services

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OUTCOME: Economically Secure Individuals and Families

GOAL: Help homeless adults become self-sufficient.

*SERVICES FOR HOMELESS**

The system of services for single, homeless adults includes numerous public and nonprofit providers. The system provides a continuum of care consisting of prevention, outreach, transitional housing, permanent housing and related supportive services designed to help homeless persons move toward greater self-sufficiency. Tier I provides year-round services for those seeking emergency shelter. Tier II consists of a variety of transitional housing and support services. Emergency shelter for those who are unwilling or unable to address their problems is provided outside the tier system.

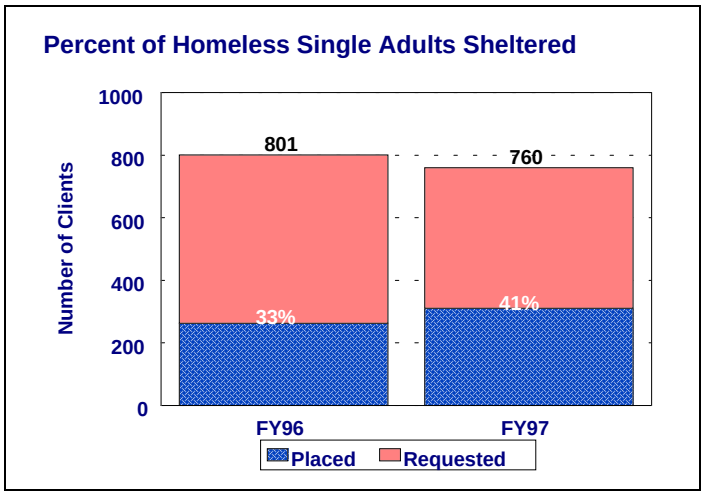
PROGRAM MEASURES

1. Percent of homeless, single adults sheltered.
2. Percent of homeless, single adults placed in transitional housing.
3. Percent of homeless, substance abusing individuals who engage in treatment.

TREND ANALYSIS

Estimating the number of homeless individuals is difficult and depends on how "homelessness" is defined. There is some consensus in the literature regarding the prevalence of the homeless in the general population. Data for these estimates are taken from jurisdictions such as New York and Philadelphia, which can produce an unduplicated count of those served (Montgomery County will have the capacity to generate an unduplicated count in FY99). It is estimated that in any given year, the size of the homeless population is between 1% and 1.5% of the population in urban jurisdictions. There are no such estimates for suburban jurisdictions.

Program Measure 1. Percent of homeless, single adults sheltered.

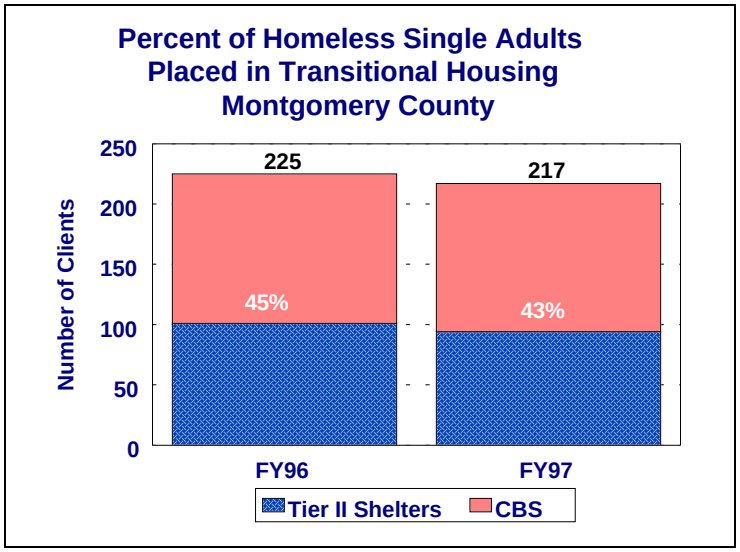


*This report does not include data for homeless families as these services have been administered separately and the data collection efforts were not compatible with the data for single homeless adults. In May 1998 a new information management system, called ANCHoR, will become operational and will allow data collection for both homeless single adults and families.

- The data charted represent homeless, single adults who came to the Crisis Center to request emergency shelter. The FY96 and FY97 data indicate that emergency shelter was not provided for a substantial number of requests because until FY98 there were no emergency shelter services available for single adults from March through November.

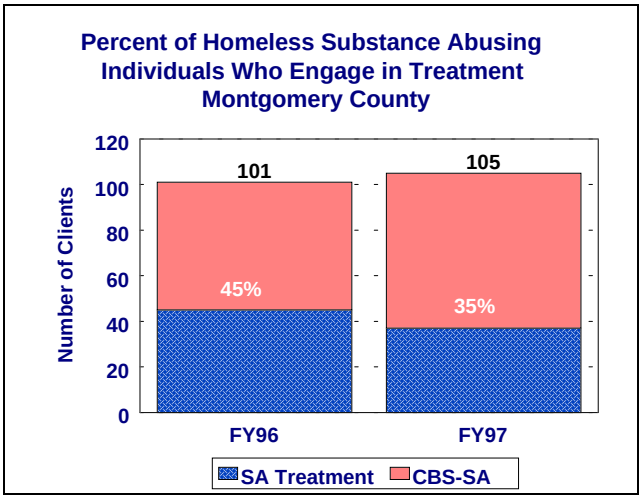
- During FY97, there were several substantive enhancements in the shelter system that have begun to reduce those requests for emergency shelter not accommodated. In January 1997 the county opened a permanent site for the Community Based Shelter (CBS). Religious communities continue to rotate volunteers to staff the shelter. Also, Sophia House opened in April 1997 to provide emergency shelter for homeless mentally ill or dually diagnosed women (substance abuse and mental illness) during the months that the Rainbow Shelter is closed. Safe Havens added services to provide shelter to the most vulnerable adults. Recuperative care beds became available to allow those individuals needing shelter following a hospital stay to get needed services. During FY98, Community Development Block Grant funds were obtained to allow the trailers used for emergency shelter in the winter to remain open all year. Previously, they were open only from November 1 to March 31.

Program Measure 2. Percent of homeless, single adults placed in transitional housing.



- To move from the Community Based Shelter to one of the transitional housing sites (Tier II shelters), homeless individuals must demonstrate efforts to address the underlying causes behind their homelessness. Transitional housing sites, which are operated by private agencies with county support, include Shady Grove House, Bethesda House, Carrol House and Chase Partnership. In FY97, 43% were able to be placed in transitional housing, down from 45% the previous year. The percentage of homeless individuals entering transitional housing is affected not only by the percentage of Tier I clients ready to move on to transitional housing, but also by the lack of availability of transitional housing beds due to low turnover.

Program Measure 3. Percent of homeless, substance abusing adults placed in treatment.



Note: Data represent those entering treatment in DHHS' Adult Addiction programs through the Community Based Shelter only. Data are not available on those homeless individuals who enter the program through other referral sources or who receive treatment elsewhere.

- The data represent adult males assessed by the Community Based Shelter to have a substance abuse problem and who moved on to a specialized substance abuse Tier II shelter. Approximately 50 percent of the total served by the CBS have substance abuse problems, and about 35 percent of those participated in substance abuse treatment in FY97. Because the numbers of clients involved are so small, an apparent difference between FY96 and FY97 may not reflect a true difference.
- The number of clients moving to a specialized shelter for substance abuse is significant because this step indicates that they are successfully engaged in outpatient substance abuse treatment and are becoming increasingly self-sufficient.

WHAT WORKS

Research suggests that to increase the likelihood that a homeless individual will become self-sufficient, a mix of housing and services is needed. Further, interventions are most likely to be effective if they are based on data specific to cultural and ethnic subgroups and if they address barriers that prevent different groups from moving through the system. For example, outcome data could be used to develop and test interventions that reflect the different service needs of those who are chronically homeless versus those whose homelessness is transitional or episodic.

To address the problem of homelessness, it is necessary to target services to subpopulations. In particular, special needs populations, such as those with serious mental illness, chronic substance abuse, or the dually diagnosed, are groups for whom the problem of homelessness is unlikely to be effectively dealt with until the underlying disorder is treated.

STRATEGIES

To help homeless adults become self-sufficient, DHHS will:

- Monitor the impact that enhanced resources have on the number of single adults obtaining shelter.
- Evaluate ways to increase bed space in Tier II shelters to substantially increase the percentage of adult individuals in the CBS who are able to transfer and thus move toward self-sufficiency.

- Continue work toward increasing the amount of permanent housing available to allow individuals to make the transition from Tier II.
- Increase the percentage of homeless adults with substance abuse problems who enter treatment by providing additional case management at the site that homeless services are delivered.

In addition, over the next year DHHS will:

- Fully implement the ANCHoR data system to capture and develop credible demographic, utilization, and treatment outcome data on all individuals and families participating in homeless services in Montgomery County.
- Develop program measures on the effectiveness of services to homeless families.

COORDINATION OF EFFORTS

Programs within HHS that contribute to the outcome:

LEAD PROGRAMS
CRISIS, INCOME, AND VICTIM SERVICES • **Prevention and Crisis Intervention** • **24-Hour Crisis Center**

OTHER HHS PROGRAMS
CRISIS, INCOME, AND VICTIM SERVICES • **Partner Abuse Services**
CHILDREN , YOUTH AND FAMILIES • **Child Welfare Services**
AGING AND DISABILITIES • **Assessment Services**
PUBLIC HEALTH SERVICES • **Tuberculosis Services**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES • **Addiction Services Coordination** • **Outpatient Addiction Treatment** • **Jail Addiction and Community Re-Entry Services** • **Adult Outpatient Mental Health Services**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT DEPARTMENTS OR AGENCIES*	*OTHER PARTNERS*
Montgomery County Police Department	**Department of Human Resources**	**Community Ministries of Rockville**
Housing Opportunities Commission	**Department of Health and Mental Hygiene**	**Community Ministry of Montgomery County**
Department of Housing and Community Affairs	**City of Gaithersburg**	**Coalition for the Homeless**
	City of Rockville	**Associated Catholic Charities**
		St. Luke's House
		Oxford Houses
		Montgomery Community Residences
		Community Vision
		Community Clinic, Inc.
		Mental Health Association of MC
		Community Based Shelter
		Mobile Med
		Emergency Assistance Coalition
		Shepherd's Table
		Lord's Table

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OUTCOME: Adults with Disabilities Participating in the Community

GOAL: Increase stability for people with mental illness.

ADULT MENTAL HEALTH

Adult mental health services include psychiatric treatment, case management, individual and group therapy, and outreach services for adults with severe and persistent mental illness. A network of public and private agencies provides a range of therapeutic and support services.

PROGRAM MEASURES

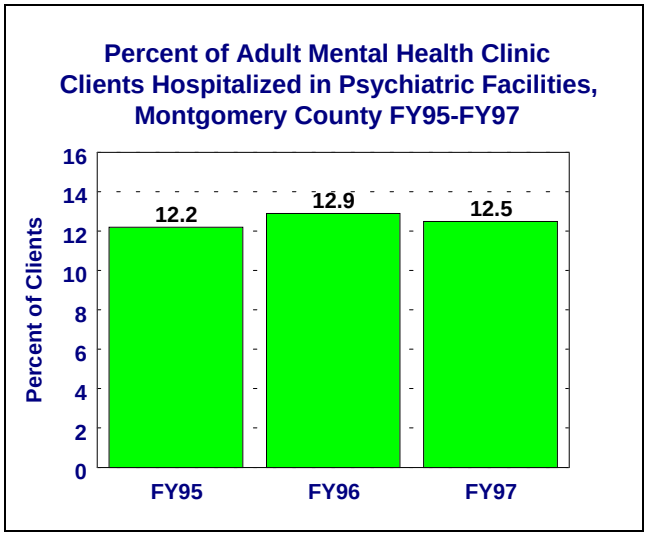
1. Percent of adult mental health clients hospitalized in psychiatric facilities.

TREND ANALYSIS

The mental health service delivery system in Montgomery County is undergoing dramatic changes as a result of managed care and Medicaid reform. This has resulted in changes in the traditional role of County public mental health from directly providing services to coordinating and overseeing a complex network of privately provided services. In FY98, a three-year plan to privatize all County-operated mental health clinics was initiated. Persons previously provided outpatient mental health services in County-owned and operated facilities were directed to private mental health service providers. The goal is privatization of all mental health clinic services by the year 2000.

Experience has shown that individuals with serious and persistent mental illness, untreated, are at greater risk of homelessness, incarceration and abandonment by exhausted relatives and caregivers. This negatively affects the larger community as well as the individual. These individuals are also at greater risk of repeat hospitalizations, the most costly and least effective long-term strategy.

Program Measure 1. Percent of adult mental health clients hospitalized in psychiatric facilities.



Note: Data currently included in the graph reflect county clinic patients only. In the future, effectiveness measures will track all clients using Medicaid reimbursed services.

From FY95 through FY97, the percent of county mental health clinic clients hospitalized remained fairly steady at 12% to 13%. The percentage of clients who are hospitalized while in treatment is an indicator of the effectiveness of treatment services for clients with serious and persistent mentally illness. Every hospitalization reduces the likelihood of the individual returning to the same level of functioning. This is particularly true of individuals who have abruptly stopped taking their medication, since there is evidence that when they return to the medication it is not as effective as before.

WHAT WORKS

Research has shown that without adequate community-based resources, patients with severe and persistent mental illness often develop increasingly more severe symptoms, resulting in a series of hospitalizations. In terms of monetary, human, and societal costs, hospitalization is the least effective method of caring for the chronically mentally ill. Reducing mental health hospitalizations significantly contributes to the stability, health and self-sufficiency of clients.

Clients with severe and persistent mental illness need the following: prompt access to care; crisis help when needed; coordinated care; education follow-up to encourage adaptive behaviors (to avoid future crisis); and care management to link the client with other needed services and support networks. It is especially important to educate and support families and friends so they may adequately serve as resources to the client and as an early-warning system to caregivers. The consistency of medication is critical to improved stability; therefore, early and continued stabilization strategies increase the potential for these individuals to participate in the community.

There is strong evidence that assertive community treatment teams are one of the most effective strategies available for seriously mentally ill patients. These teams provide services in the client's own environment, rather than through more traditional mental health counseling settings. The focus is on developing and educating people who are part of the client's natural support network to establish a system for ensuring that the client takes appropriate medication, accesses needed services and has a mechanism for getting help in a crisis.

STRATEGIES

To increase stability for people with mental illness, DHHS will:

- Continue to provide immediate access to care:

  Montgomery County already has a strong system in place to ensure immediate access to care. Clients in crisis may be referred to the 24-hour Crisis Center for evaluation and referral. If immediate hospitalization is needed, clients may be referred to one of the four county hospitals with psychiatric services, or may be referred to McAuliffe House, a community-based alternative to hospitalization. Clients may receive outpatient services at either the county-staffed clinics or at one of the private contract providers. Clients eligible for Medical Assistance receive outpatient treatment through one of the providers participating in the Medical Assistance program. All of these components are seen as instrumental in reducing the hospitalization rate for mental health consumers.

- Monitor the effectiveness of the new mental health delivery system of private managed care and fee-for-service providers through the Core Service Agency and Maryland Health Partners.

- Follow-up on the January 1998 Mental Health Planning Committee recommendations for reorganizing mental health services in Montgomery County.

- Reallocate savings from privatization to address service gaps.

    - Create an Assertive Community Treatment Team to target hard-to-serve clients for whom other treatment forms have been unsuccessful. This team would be part of the Transitional Case Management Team in the Crisis Center.

    - Continue and expand the multicultural team approach to provide outreach to troubled minorities; e.g., expand mental health treatment services targeted to Hispanic seniors.

    - Increase efforts to integrate services within DHHS and between DHHS and its private partners.

    - Expand mental health education and consultation to the community.

These strategies, taken together, will provide a well-rounded system of care for the mentally ill in Montgomery County with a focus on prevention and systems of care.

COORDINATION OF EFFORTS

Programs within HHS that contribute to the outcome:

LEAD PROGRAMS
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES • **Adult Outpatient Mental Health Services** • **Core Service Agency**

HHS PARTNERS
CHILDREN, YOUTH AND FAMILIES SERVICES • **Child and Adolescent Mental Health Services** • **Child Welfare Services**
AGING AND DISABILITY SERVICES • **Assessment Services**
CRISIS, INCOME, AND VICTIM SERVICES • **24-Hour Crisis Center** • **Prevention and Crisis Intervention** • **Shelter Services**
PUBLIC HEALTH SERVICES • **STD/HIV Prevention and Treatment** • **Tuberculosis Services** • **Women's Health Services**

OTHER PARTNERS

Other partners that contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT AGENCIES/DEPARTMENTS*	*OTHER PARTNERS*
Housing Opportunities Commission	**Department of Health and Mental Hygiene (DHMH)**	**CPC Health**
	Maryland State Department of Education, Division of Rehabilitation Services	**Montgomery General Hospital**
	Legal Aid Bureau, Inc.	**Mental Health Association**
	Washington Metropolitan Area Transit Authority	**St. Luke's House, Inc.**
		Alliance for the Mentally Ill
		McAuliffe House
		Family Services of Montgomery County/ Montgomery House
		Threshold Services, Inc.
		Maryland Health Partners
		Affiliated Sante Group

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OUTCOME: Economically Secure Individuals and Families

GOALS: ***Increase employment for both those seeking and receiving welfare benefits.***
Decrease cost per recipient.

WELFARE REFORM

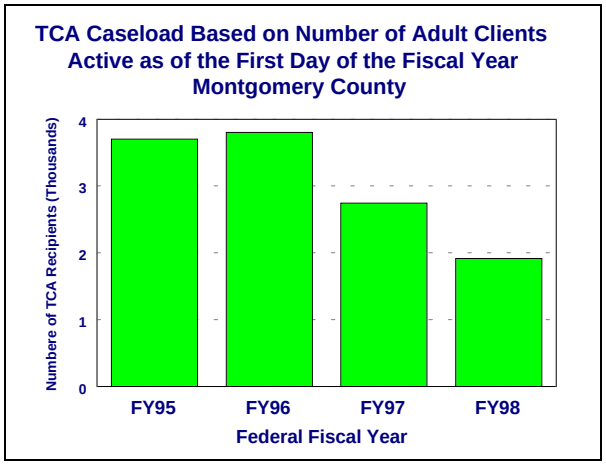
Welfare reform strives to divert residents from dependency on cash assistance and empower them to achieve their full economic and human potential by providing assistance with employment, child care, and child support collection, and by placing time limits on eligibility for cash assistance. Services are provided by a network of public and private providers. DHHS contributes a variety of services, including Temporary Cash Assistance (TCA) formerly known as " Aid to Families with Dependent Children," and commonly referred to as " welfare," employment services and child care assistance.

PROGRAM MEASURES

1. Percent of Temporary Cash Assistance *applicants* who become employed before payment of benefits begins.
2. Percent of Temporary Cash Assistance *recipients* who become employed.
3. Average monthly benefit cost per Temporary Cash Assistance recipient household.

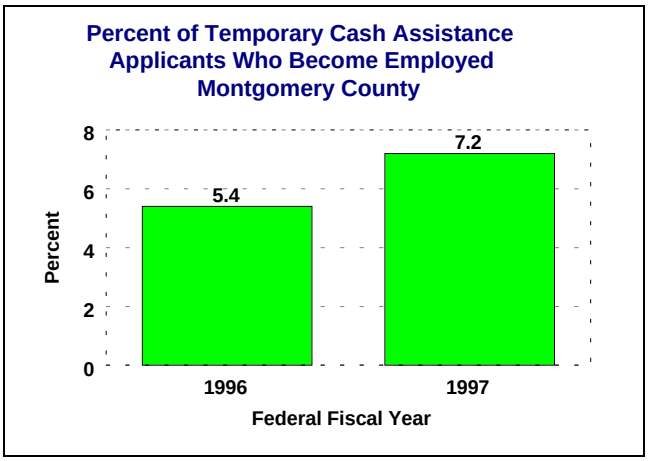
TREND ANALYSIS

Montgomery County began reforming its welfare system in 1995, two years before the state and federal governments passed legislation mandating changes in welfare. Temporary Cash Assistance is administered through DHHS. All applicants, unless exempt due to disability or other specifically exempted situations, are now required to look for work before they can begin collecting benefits.



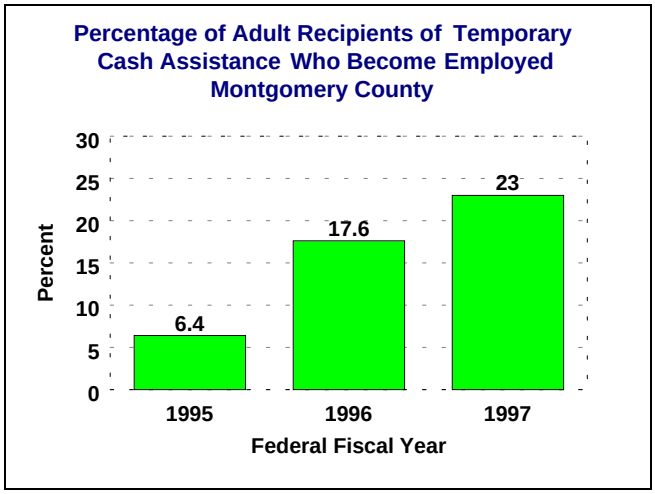
Between January 1995 and February 1998, the TCA caseload decreased 58.6%.

Program Measure 1: Percent of Temporary Cash Assistance *applicants* who become employed before payment of benefits begins.



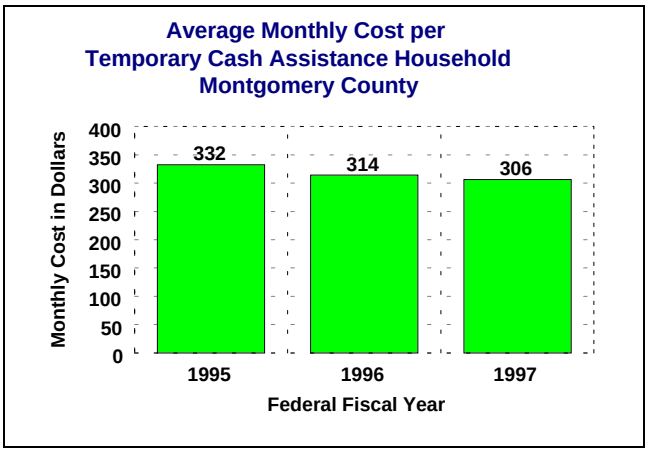
In May, 1996 DHHS began implementing strategies that would help residents find work when they came to apply for benefits to prevent them from needing TCA payments. Since then, the percentage of TCA *applicants* who became employed and never needed to start receiving TCA payments rose from 5.4% to 7.2%.

Program Measure 2: Percent of Temporary Cash Assistance *recipients* who become employed.



The percent of welfare *recipients* who became employed increased from 6 percent in 1995 to 23 percent in 1997. Montgomery County received a cash bonus of over $100,00 from the Maryland Department of Human Resources in 1995 for its success in placing welfare recipients in jobs. The bonus was provided to the Private Industry Council, which was the employment services vendor at that time.

Program Measure 3: Average monthly benefit cost per Temporary Cash Assistance recipient household.



Although employment is the primary goal to support self-sufficiency, some TCA recipients continue to need partial benefits even after finding employment. The increasing number of TCA recipients who are employed but are still eligible for reduced benefits has resulted in a reduction in the average benefit cost per recipient household by 8 percent since 1994. This measure reflects an improvement in the economic independence of the family.

WHAT WORKS

Research indicates that the most effective strategies to increase earnings and reduce Temporary Cash Assistance payments include the following: 1) strong child care assistance, 2) effective job placement and retention services, 3) accessible transportation and health care and 4) partnerships with the community. A highly successful program in Ottowa County, Michigan reported that by September 1997, all former recipients had found some form of employment. In this small, largely rural county, churches and other community groups formed partnerships with the county to encourage individuals and businesses to take responsibility for ensuring that all welfare recipients had an opportunity to work. In addition to creating jobs, community members became mentors for applicants and recipients, helping with child care, job searches, and transportation.

STRATEGIES

To achieve the goal of increased employment for applicants and recipients of TCA and to decrease the benefit cost per recipient, the department will focus on the following strategies:

Monitor the new employment strategies to make sure they work.

DHHS has expanded its partnerships with the business community and strengthened its employment services in four main areas: job development, job readiness, job placement, and post-employment services.

Advocate to expand the income limits for child care eligibility to ensure that the working poor are able to work.

Montgomery County has two programs for assistance with child care. The state funded Purchase of Care (POC) program provides child care subsidies for only the lowest-income families, including those receiving Temporary Cash Assistance (TCA) benefits and other eligible residents. DHHS has strengthened child care services by successfully working with the Maryland Department of Human Resources (DHR) to increase its payments to child care providers participating in the Purchase of Care Program, to assure that adequate child care resources are available.

The county-funded Working Parents Assistance (WPA) program provides subsidies for families who are not eligible for the Purchase of Care program due to income level. The WPA program has received national recognition, especially for its policy requiring applicants to pursue child support payments. This program provides a critical support to families moving from welfare to work. However, based on the high cost of living and of child care in Montgomery County, the income limits for eligibility for child care are often unrealistic.

Expand transportation and health benefit options.

Based on the decrease in each jurisdiction's TCA cases, the Maryland Department of Human Resources returns to each jurisdiction a percentage of the funds saved to be used to expand services to support employment and self-sufficiency. As a result of its success in decreasing its cases, Montgomery County has received $1.6 million over each of the last two years to broaden its network of supportive services, including employment services, transportation, emergency assistance, welfare avoidance grants and funds for other needs which support the individual's ability to begin or sustain employment.

The department will continue to evaluate and request reinvestment in local support services which are the most effective in helping divert families from dependency on cash assistance. The availability of health benefit options are important for families whose transitional benefits are coming to an end. To prevent families from needing to return to TCA to obtain health coverage, other options must be identified.

Strengthen community partnerships.

The department has identified a community partner to provide mentoring services for families with complex issues that have been barriers to employment and self-sufficiency. Additionally, a local nonprofit organization has been identified to provide third-party representation for children eligible for the Child Specific Benefit. These are children born to current recipient families but ineligible for addition to the family TCA grant due to changes in the law. Financial support for the partners providing these services has been identified through welfare reform reinvestment funds.

A Welfare Reform Resource Information Center is being created to serve as a single point of contact to effectively link community resources and interests with the needs of customers who are in the process of moving from welfare to work.

Evaluate whether desired outcomes are being achieved.

One area of concern has been whether changes in the welfare system would result in increases in other social ills. According to preliminary data from a statewide study by the University of Maryland, changes in welfare have not resulted in an increase in child abuse and neglect complaints. DHHS has applied for funds from the Maryland Department of Human Resources to conduct a study to determine what happens to applicants who do not complete the Temporary Cash Assistance application process, to

determine if outcomes are being achieved and to identify any unintended negative impact of welfare reform on the well-being of the family.

COORDINATION OF EFFORTS

Programs within DHHS that contribute to the outcome:

LEAD PROGRAM
CRISIS, INCOME, AND VICTIM SERVICES • **Public Assistance Benefits Certification** • **Prevention and Crisis Intervention**

OTHER HHS PROGRAMS
CRISIS, INCOME, AND VICTIM SERVICES • **Partner Abuse Services** • **Rental Assistance** • **Transitional Housing and Service**
ADULT MENTAL HEALTH AND SUBSTANCE ABUSE • **Addiction Services Coordination** • **Outpatient Addiction Treatment**
PUBLIC HEALTH SERVICES • **Care for Kids Program**
CHILDREN, YOUTH, AND FAMILY SERVICES • **Child Care** • **Conservation Corps**

Other partners who contribute to the outcome:

OTHER COUNTY DEPARTMENTS OR AGENCIES	*OTHER GOVERNMENT AGENCIES/DEPARTMENTS*	*OTHER PARTNERS*
Public Works and Transportation Department	**Department of Human Resources** • **Family Investment Administration** • **Child Support Enforcement Administration** • **Child Care Administration**	**Community Ministry of Montgomery County**
Housing Opportunities Commission	**Department of Labor, Licensing, and Regulation**	**Families Foremost**
Montgomery College		**MAXIMUS, Inc.**
Offices of the County Executive, Community Outreach		**Workforce Development Corporation**
		Helping Hand Shelter
		Child Care Connection
		Interfaith Clothing Center
		Mental Health Association of Montgomery County, Inc.

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Montgomery County Department
of Health and Human Services

Measuring Progress

The
Data
Agenda

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THE DATA AGENDA

Data management systems are crucial to measuring progress in achieving outcomes. Building databases, developing tools and applications, and constructing a telecommunications infrastructure that allows the department and its community partners to track program and community progress is essential to achieving results. Data collections methods differ, timeliness of data availability varies according to whether the data is housed locally or by the state, and data quality fluctuates widely depending on the source and collection methods used. Improvements in the type of data collected, the systems and methods used to collect and analyze the data, timeliness and quality of data constitute the "Data Agenda".

As we strive to build a safe, healthy and self-sufficient community, we will make choices about where and when to invest our resources to develop better data management systems to ensure that the best data and the best available data are one and the same.

Community-wide Indicators

The indicators that were selected to show us where Montgomery County stands on the path to successfully achieving the outcomes represent the best available data. What the department has learned is that often times the "best" data available are not necessarily the "best" data. Historically, most data has been collected to meet administrative requirements, not to measure outcomes. Data that are maintained by state agencies, such as vital statistics maintained by the Maryland Department of Health and Mental Hygiene (DHMH), often lag behind as much as two years. Tracking Montgomery County's progress on reducing infant mortality, for example, is hampered by such a lag. This is a problem that cannot be corrected by DHHS alone and will require a partnership between county officials and DHMH to improve the timeliness of reporting such data.

Tracking the use of substances in our high schoolers presents another problem. The data that is used in this report is based on a survey that is conducted every two years by the Maryland State Department of Education (MSDE). To track the effectiveness of our prevention programs requires more frequent data collection. Because the survey is funded and conducted by MSDE, changes there will also require a county/state partnership

As noted earlier, indicators have not yet been chosen for three outcomes: *Healthy Older Adults, Children Ready for School* and *Children Succeeding in School*. In addition, academic indicators have not yet been selected for *Young People Making Smart Choices*.

- ***Healthy Older Adults:*** The focus groups and community forums sponsored by Montgomery Common Ground made the department aware of the community's concern about the health of its older citizens. Through these forums and by reviewing research, the department also learned that there is not yet a consensus about which data are true indicators of health and well-being in older adults. In recent years, the medical community has shifted its focus from simply adding years to life to adding life to years (quality of life). To measure the well-being of older citizens, according to this approach, the focus would shift from measuring mortality rates for the most common diseases (since everyone dies eventually of something), to measuring the quality of life of our older residents. To develop a core set of indicators for this outcome--and for other outcomes related to older residents--the department will engage in discussions with geriatric professionals, researchers, and older citizens to develop a core set of outcome indicators for health-related quality of life indicators for older individuals.

- ***Children Ready For School:*** The data that are available on children are either vital statistics data kept by the state or DHHS (e.g., infant mortality, birth weight) or data collected by the school system. Data on children between the time they reach one year of age until they enter school is scarce and incomplete. The department will work through the Collaboration Council for Children, Youth and Family's Interagency Early Childhood Committee and other interested groups to develop indicators for this outcome.

- ***Children Succeeding in School:*** Montgomery County Public Schools (MCPS) collect and report on many indicators of how children are doing. DHHS will work with MCPS over the next year to select the best indicators for this outcome.

- ***Young People Making Smart Choices:*** This year, under the leadership of the County Executive's Office, DHHS joined with eight other county departments to achieve better results for our young people. This group identified a set

of indicators in the areas of juvenile crime, sexual behavior, and substance abuse. These are important areas to consider. In addition, however, because many of the choices young people make in school can have ramifications for success in later years, *The Young People Making Smart Choices Work Group* recognized early the need for school-related indicators. Over this next year, the work group will collaborate with MCPS to select the best indicators of young people making smart choices in school. The work group will also focus on developing indicators that measure positive behaviors rather than negative ones. One potential area that has been identified is fitness. The work group will explore possibilities of developing a fitness indicator with the Maryland Department of Health and Mental Hygiene, the Maryland State Department of Education, and the Montgomery County Public Schools.

Program Measures

During this next year, DHHS will develop additional program measures and will focus on measuring progress for the department's priority initiatives. It is our goal to track how effectively our programs and initiatives serve people. The questions we seek to answer are: "Do the people we seek to help benefit from the strategies we are using? Do the programs, policies and initiatives we are using make the greatest possible difference in their lives?"

Welfare reform: This year we tracked several program measures, including how many TCA clients were moved to employment and the average monthly grant. Our goal, however, is not simply to move people off welfare, but to move people toward self-sufficiency. To get a better sense of how well we do this, we would like to know more, such as how many of people remained on the job for six months or a year. We will work with the state and our community partners in an effort to develop additional data, especially regarding how well former clients do over time. Collecting this type of data is expensive and time consuming. Further study and discussion will be required.

Systems reform for children's services: The county is moving toward an integrated system of services to be planned, managed, and evaluated by the Collaboration Council. One key component to help us know whether a child who enters this system improves over the course of services is a client tracking system that assesses a child's well-being across time. Such a system would not only track the types of services that a child is provided, such as mental health or child welfare services, but would also assess the impact of those services on the child's functioning through measures such as academic performance , school attendance and contacts with the police. Such a system will require time, money and technical expertise to construct and implement.

Aging of the population: Many of the services provided by DHHS' Aging and Disability Services are designed to help maintain frail seniors safely in the community. To reach this goal, it often takes more than a single service; it takes a web of services that is spun by a case manager. To get a full picture of what services are used to reach the goal and to track whether clients are benefiting from the services--are they safer?--DHHS will begin implementing a data management system that tracks all clients entering Aging and Disability Services from intake and allows managers to track client safety and health across time. In addition, the department will need an instrument that will allow case and program managers to measure levels of safety and risk in clients. DHHS staff will develop such an instrument over the next year and will pilot its validity and reliability.

Medicaid reform and reform of the mental health delivery system: DHHS will work with the Maryland Department of Health and Mental Hygiene and with Maryland Health Partners to select measures that will allow us to track the health and mental well-being of clients in this new system.

Services for homeless individuals and families: DHHS anticipates that the ANCHoR data collection system will be fully operational by the end of FY99. This system will allow DHHS to track clients' movement toward self-sufficiency. This system will provide managers with information about how well the system helps clients to make use of treatment services that will ameliorate some of the underlying causes of homelessness.

This is a large agenda and DHHS will not complete all the work this next year. But these are the agenda items we believe are most pressing at this time.

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DHHS And Community Partners Working Together To Achieve Results

Listed below are some of the community-based initiatives DHHS began working with in FY98. We will continue to work strategically with these initiatives and others to achieve the community outcomes.

- Collaboration Council:
  - ✓ Children's Agenda
  - ✓ Interagency Early Childhood Committee
  - ✓ Comprehensive System of Mental Health Services for Children in Montgomery County (Substance Abuse and Mental Health Services Administration Grant)
- Juvenile Justice Initiative: Comprehensive Strategy
- Kids Count: Advocates for Children and Youth
- Linkages to Learning
- Mental Health Planning Committee: Reorganization of Mental Health Services in Montgomery County
- Montgomery United Way
- Pathways School
- Potomac Valley Section of the National Council of Negro Women
- Silver Spring Outcomes Initiative
- Systems Reform Initiative: Vision To Scale
- Montgomery County Youth Advisory Committee: Youth Speak Outs
- Senior Mental Health Committee

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ACKNOWLEDGMENTS

Our work in creating a results-based accountability system has been based on a model developed by Mark Friedman of the Fiscal Policy Studies Institute. We appreciate his generosity of time and counsel as we moved through a challenging and rigorous process. Mr. Friedman offered us not only a model structure for our endeavor but also the state and national perspective on this issue. His sincere concern for the difference we make in the lives of people we serve heartens and encourages us.

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The Schaefer Center for Public Policy, University of Baltimore, provided research and information to help us identify the "cost of bad outcomes." The work of George Rawson, Larry Thomas and Lenneal Henderson enables us to better evaluate the financial and human implications of early intervention services as we move forward.

We have also benefited from a review of many other state and local efforts designed to focus on achieving results in government. We have sought to incorporate the best elements of these efforts and to learn from their experiences.

Montgomery Common Ground work group members provided the perspective of individual residents as well as service providers in creating this new way of doing business. We are especially grateful for the work of Harriet Guttenberg, who served as volunteer chair of Montgomery Common Ground, for her untiring efforts to improve service delivery in this community.

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